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The significant patterns of behavior in children indicating a need for close scrutiny by a teacher are held to be: inability to learn, unsatisfactory interpersonal relationships, inappropriate behavior, unhappiness, repetitive symptoms of illness after stress. Research was designed to validate a screening process using teacher, peer, and self-ratings which had been developed for early identification of emotionally handicapped pupils who are vulnerable to learning and behavior problems in school. Results indicated that the collection of data within the school setting (rating of behavior by teachers, peers and pupils as well as estimates of intelligence and socio-economic status) can be meaningfully and usefully combined to screen a group of pupils who would later be diagnosed by clinicians as having from moderate to extreme degrees of emotional handicaps manifest in school adjustment difficulties.

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DEVELOPMENT AND VALIDATION OF A PROCESS FOR SCREENING EMOTIONALLY HANDICAPPED CHILDREN IN SCHOOL

COOPERATIVE RESEARCH PROJECT NO · 1186

CALIFORNIA STATE DEPARTMENT OF EDUCATION · SACRAMENTO

MAX RAFFERTY · SUPERINTENDENT OF PUBLIC INSTRUCTION · 1963

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THE DEVELOPMENT AND VALIDATION OF A PROCESS FOR SCREENING EMOTIONALLY HANDICAPPED CHILDREN IN SCHOOL

Cooperative Research Project No. 1186

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Sacramento, California
1963

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Preface

If schools are going to provide more adequately for those children who cannot be educated in existing educational programs because of emotional handicaps manifest in learning and behavior difficulties, they must find ways of locating those youngsters with problems long before the difficulty has become firmly imbedded in the child and developed beyond the capacity of the school to provide help. Early identification has long been acknowledged as the first step in preventing the costly results of school failure. Project 1186 is a final step in a long journey begun in 1955 by staff members of the California State Department of Education to develop a means for using existing school information to identify the child who is vulnerable to failure and who will not succeed without modification of the school program.

The California State Department of Education
and
the staff of Project 1186

wish to express appreciation to

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The Development and Validation of a Process for Screening
Emotionally Handicapped Children in School

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Chapter I - INTRODUCTION

That the mentally retarded and physically handicapped child has need of and can benefit from educational experiences is readily accepted by educators and laymen alike. Contrasted with this attitude of acceptance of the needs of the obviously handicapped pupil, is an attitude of rejection toward children with educational potential within the normal range, whose school behavior is complicated by resistance to learning and to school rules, and by an inability to get along with others. Often, education is defined as a process which should be provided only for those who are "willing" to learn and function in school. While the role of the school in educating the mentally and physically handicapped is well accepted, there is evidently a fairly confused image of the responsibility of education toward unwilling learners who find it difficult to profit from existing educational programs. While they are rarely ejected from school, there is little interest in integrating them into a successful learning program.

Developing educational programs for the child with learning and behavior difficulties has, in addition to the hurdle of defining the responsibility of education, the hurdle of delineating that part of the child with which the school can be expected to cope, meanwhile leaving to the mental health specialist those areas of inadequate functioning which are his domain. We do not, apparently, have concepts as clear cut in the case of the child with emotional problems manifested by learning and behavior difficulties as we do, for example, in the case of the child with cerebral palsy. In this case the medical specialist has the responsibility for the regimen of diet, medicine and exercise necessary for physical health, the physical therapist has responsibility for the development of defective or limited muscular control, the speech therapist focuses on the speech handicap, and the educator is concerned with the responsibility for developing the educational potential of the child. In this example each professional person appears to have a reasonably clear cut responsibility. When emotional and psychological problems are the principal source of the difficulty, the professional roles are less well-defined. One can expect to hear a teacher say, "But he shouldn't be in a remedial reading program until his parent problems are cleared up," or "What can I do for her in school when she is in another world?" We treat the child with emotional problems often as an *auslander* whose thoughts and experiences are not comprehendable nor worth comprehending. His rejection of education is tantamount to rejection of the educator. With a disturbed child's volatile inner life expressing itself in any variety of unpredictable ways, educators are bound to ask, "Can the school really be expected to educate children like that?"

Next to the family the school is the most important primary institution to influence the life of the child. All children must pass successfully through this experience in order to become adults who are able to find satisfaction in achievement, to make a contribution to society, to be effective parents and to enjoy leisure time activities. One of the notable accomplishments of public education in America is that today nearly all children attend school. The National Education Association statistics (96) on the percent of the school age population enrolled in the public elementary and secondary schools of the fifty states in the United States indicate that in 1959-1960, 83.6 percent of the nation's pupils were enrolled. The range of enrollment varied from California with the highest at 97.4 percent to Rhode Island with the lowest at 69.2 percent. One of the reasons that California has such a high percent of pupil enrollment is that for many years the special education programs for the mentally and physically handicapped have been increasing the ability of California's schools to provide an educational program for more pupils.

Since California has an established precedent for educating all educable children, it follows that as long as children with emotional problems are "educable," they have a legal right to an education. It is not surprising then, that California, which already had mandatory vision and hearing screening and other types of programs to screen the mentally retarded and physically handicapped programs, sought, several years ago to develop procedures for identifying children with emotional difficulties and to explore and define educational methods which would be most effective and appropriate for them. In January 1960, Roy E. Simpson, Superintendent of Public Instruction for the State of California, submitted the following letter of transmittal along with a report on the preliminary efforts of the Research Staff of the California State Department of Education to identify early, and provide educational adjustment for, emotionally handicapped pupils in California's public schools.

> "Almost all children go to school today. Public schools are privileged to serve mentally retarded and severely mentally retarded children, physically handicapped children, children in hospitals and juvenile halls, and those needing instruction at home. Compulsory school attendance laws bring the public school in close contact with some children who are unable to learn because of minor, moderate, or serious emotional disabilities. They are children who may be disturbing or disruptive, tough, anxious, fearful or bizarre. They come to school unable to shake inner thoughts sufficiently to learn, or too hostile to permit the expenditure of energy in learning. They learn by their own failure and resentments and are repelled by the anxieties of their classmates and instructors. They are punished, cajoled, threatened, expelled, suspended, tolerated and disciplined with little effect.
>
> Many of these children will one day be part of our society who will seek revenge, retribution or withdrawal from life. They will become part of the vast population in prisons, mental hospitals, alcoholic wards. They will be found among the accident prone, the narcotic addict, the suicidal, and the melancholy. They will be seen in divorce courts, lonely rooms, mental hygiene clinics, on city streets and farms.
>
> The problem which these children present to the school is also an unequaled opportunity. For, if all the children of all the people are to attend school, then it is possible to affect such children positively and to prevent to some extent the development of the tough, the anxious, and the defeated. If such individuals are created by adverse factors in their social environment, it is reasonable to assume that other positive factors in their educational experiences can be brought to bear to counter or reduce their vulnerability.
>
> The research program presented herein represents the first known major attempt by any branch of government to identify early those children who will need some educational assistance because of emotional problems and to discover ways of helping them within the school program. It represents an eminent attempt to prevent wasted human lives and to reduce the immense financial burden unequaled by any other human disorder.
>
> No state which expends vast sums for prisons, mental hospitals, clinics, youth camps, and inadequate families can overlook the possibility that his burden can, to some extent, be reduced or prevented. Such is the hope of this research effort." (13)

Chapter II - BACKGROUND OF THE STUDY

A. A Definition of "Emotionally Handicapped"

The definition of "emotionally handicapped children" and its operational implementation in the school are necessary prerequisites for this research endeavor. Emotional health can be inferred from the degree of freedom an individual has to choose from alternative kinds of behavior. When one's choices are moderately or severely limited by emotional lacks or injunctions, one's behavior can be regarded as handicapped. For example, the physically handicapped child is one whose physical disability prevents him from participating in a number of activities. His degrees of freedom of choice from among different activities are a function of the severity of his handicap. In addition, the child with an impoverished home environment who has been labeled socially handicapped also can be considered to have restricted degrees of freedom, even though the reversability of his condition and the probability of remediating his situation may be greater in his case than in the case of the physically handicapped child. Not only physical, but also social and emotional limitations or restrictions serve to reduce the individual's relative freedom of choice in social and educational endeavors. The reduction of personal maneuverability and flexibility in a changing environment which can be conceptualized as a kind of paralysis increases the individual's difficulties in adapting to the pressures and changes of life. As a result, the emotionally handicapped person shows increasing susceptibility to behavioral difficulties and interpersonal friction.

The emotionally handicapped child may have health problems; he may also come from a socially impoverished environment; and he may have poor intellectual functioning. He is distinguished from his peers by behavior which is "frozen" or paralyzed by restrictive and inflexible emotional forces within the personality of the child himself.

In most people emotional problems and anti-social behavior are the results of the combined forces of genetic, environmental and personality components. Any dichotomy of these forces is a verbal construct rather than a state of nature, for the human organism lives and exists with a pre-determined genetic endowment in an ever-changing social environment. Adverse factors in the social environment act on the organism in combination with limitations emanating from within the individual. Such dichotomies can be useful, however, in thinking about the problems of human behavior, in much the same manner as a study of the variables affecting weather conditions leads to the possibility of predicting climatic conditions and modifying the immediate environment for greater comfort.

Specifically, the emotionally handicapped child is defined as having moderate to marked reduction in behavioral freedom, which in turn reduces his ability to function effectively in learning or working with others. In the classroom, this loss of freedom affects the child's educative and social experiences and results in a noticeable susceptibility to one or more of these five patterns of behavior: (20)

"1. An inability to learn which cannot be adequately explained by intellectual, sensory, neurophysiological, or general health factors.

An inability to learn is, perhaps, the single most significant characteristic of emotionally handicapped children in school. Non-learning of this kind may be manifested as an inability to profit from any school learning experiences as well as an inability to master skill subjects. The non-learner may fall behind almost imperceptibly in the first few grades but find himself in deep water by the time he reaches fourth grade. There are some students, too, who seem to be keeping pace until they reach junior high school, when they begin to flounder badly.

"By whatever symptoms the inability manifests itself, we will, as educators, seek the cause or causes. And once we have ruled out intellectual, sensory, neurophysiological, and general health factors, there remain emotional conflicts and resistances to be investigated as major causes of learning disabilities.

2. An inability to build or maintain satisfactory interpersonal relationships with peers and teachers.

It is not just "getting along" with others that is significant here. The term "satisfactory interpersonal relations" refers to the ability to demonstrate sympathy and warmth toward others, the ability to stand alone when necessary, the ability to have close friends, the ability to be aggressively constructive, and the ability to enjoy working and playing with others as well as to enjoy working and playing by oneself. In most instances, children who are unable to build or maintain satisfactory interpersonal relationships are noticed by their peers, or are most clearly visible to their peers. Teachers, however, are also able to identify many such children after a period of observation.

3. Inappropriate or immature types of behavior or feelings under normal conditions.

Inappropriateness of behavior or feeling can often be sensed by the teacher and peer groups. "He acts like a baby almost all the time," or "He acts funny lots of times," are judgments often heard that describe such behavior. The teacher may find some children reacting to a simple command, like "Please take your seat," in wildly disparate or incongruous ways. What is appropriate or inappropriate, mature or immature, is best judged by the teacher using his professional training, his daily and long-term observation of the child, and his experience working and interacting with the behavior of large numbers of children.

4. A general pervasive mood of unhappiness or depression.

Children who are unhappy most of the time may demonstrate such feelings in expressive play, art work, written composition, or in discussion periods. They seldom smile and usually lack a "joy of living" in their school work or social relationships. In the middle or upper grades a self-inventory is usually helpful in confirming suspicions about such feelings.

5. A tendency to develop physical symptoms, such as speech problems, pains, or fears, associated with personal or school problems.

Often this tendency is first noted by the child himself. Illness may be linked regularly to school pressures or develop when a child's confidence in himself is under stress. Speech difficulties resulting from emotional distress are usually painfully audible to the teacher and parent."

o sum up, then, the significant patterns of behavior in children indicating a need for lose scrutiny by a teacher are: inability to learn, unsatisfactory interpersonal elationships, inappropriate behavior, unhappiness, repetitive symptoms of illness after tress. It is important to note that the five patterns of behavior described above can e observed to some degree in all children at different times. The critical question in eference to each of them is: "How much is too much?" The general assumption underying this project is that by refining teacher judgments through the use of standardized easurement techniques and combining these judgments with the perceptions of others, he "How much is too much?" question can, in part, be answered and satisfactory and ffective (as well as economical) early identification of emotionally handicapped hildren is possible.

Emotional handicaps, like all handicaps, exist in degrees. To clarify the above operational definition, it is necessary to establish a continuum of emotional behavior from which the degree of handicap can be perceived and perhaps estimated, especially as it relates to possible action by the school. Such a continuum as the following covers the range of emotional handicaps as we understand them today:

1. Children who experience and demonstrate the normal problems of everyday living, growing, exploring and reality testing.

2. Children who develop a greater number of symptoms of emotional problems as a result of normal crises or stressful experiences such as death of father, birth of sibling, friction between parents (with possible separation or divorce), physical injury, school entrance, junior high school entrance, puberty and so forth.

3. Children in whom symptoms of moderate emotional maladjustment persist to some extent beyond normal expectations but who are able to manage an adequate school adjustment under optimum conditions.

4. Children with fixed and recurring symptoms of emotional maladjustment, who can, with help, profit by school attendance and maintain some positive relationships in the school setting.

5. Children with fixed and recurring symptoms of emotional difficulties who are perhaps best educated in a residential school setting or temporarily in a home setting.

These divisions are arbitrary and children are highly mobile within the above classification. We do not know what percentage of the school population falls within any of these categories. We can propose, however, on the basis of empirical evidence, that a great majority of school children probably fall within categories one and two, while children with school difficulties, a much smaller percentage (perhaps from 20 percent to 5 percent depending on population characteristics), will be found in category three, four or five. The goal of an early identification program is to identify children who are at level three in this continuum, in order to provide therapeutic leverages which will prevent them from developing emotional behavior on the negative side of the continuum (levels four and five).

Throughout this report the reader will find the term "school maladjustment" or "poor school adjustment" used synonomously with "emotional handicaps." Descriptions of children with emotional handicaps as those with "learning and behavior difficulties" will also be quite common. The interchangeable use of these terms is made in an effort to link the concepts of emotional handicaps described above with already existing concepts used by teachers and parents which define essentially the same types of children. The concept of emotional handicap describes the dynamics of the problems; the terms "learning and behavior problems" or "school maladjustment" describe the manifestations of the emotional handicaps. The psychologist uses the descriptive category "emotionally handicapped" to describe the child whom the parent or teacher would describe as having school adjustment difficulties or learning and behavior problems.

The Necessity for Early Identification of Emotionally Handicapped Children

The striking thing about a review of the records of children in school with learning problems, behavior difficulties, delinquency or serious emotional disturbance is that at some point in the lives of all of these children intervention by someone, or some agency, could have turned the tide of the developing disorder or at least redirected its course into more profitable channels. School programs designed to build personality strengths and develop achievements of such pupils are increasingly doomed to failure as more time passes from the first signs of a developing difficulty. All human development is characterized by ups and downs in daily and weekly adjustment and climaxed by ife crises situations. The inertia opposing early identification lies in the fact that it is difficult to know whether a sample of maladjustive behavior in a single developmental situation is indicative of serious problems later on, or merely a manifestation of the behavior of a child working through a present difficulty. For this reason teachers can be expected to be unsure of the meaning of a sample of a particular child's behavior. They know that there is at least some probability of his making improved adjustment in the next grade as he grows older. Our purpose here is not to explore educational interventions which would help ameliorate the problem and assist the pupil to better means of solving future problems of the same type, but to indicate that an understanding of the dynamic nature of human behavior has made most professional workers chary of predictions made on a few samples of behavior.

On the other hand, we are quite at home with the situation in which a teacher notes that a child has a temperature, sends him to the nurse's office and on further examination the nurse sends the child home from school for the day. The temperature may presage a serious illness, or be the result of a minor infection of some type. No one takes an abnormal temperature lightly; we accept the fact that it is a sign of some difficulty and we intend if at all possible to do something about it. In addition to concern for the welfare of the child, the teacher and nurse are concerned about the welfare of other pupils. The temporary quarantine of the child from school may prevent a breakout of some contagious illness, or a round of absences with colds or flu. The temperature may indicate a lasting problem or a temporary one; the important thing is that it is observed and preventive action is taken.

Early identification of emotional problems is fairly analogous to the taking of bodily temperatures. However, at least one obstacle to early identification is the attitude that behavior indicative of "emotional fevers" may pass away with no negative result. Educators need to make note of all poorly adaptive behavior and collaborate with other professional personnel to determine its significance and what action it calls for. The purpose of early identification of such situations is simply to make a systematic observation of the current behavior of children and take action if the behavior is out of line with what is expected of children at that age and grade. Furthermore, pupil crisis behavior may indicate, just as in the case of pupils with a temperature, the beginnings of a long term emotional difficulty or be a passing affair which will leave the child with more or less effective means of handling minor difficulties. What happens as a result of the crisis depends to some extent on what happens to the child during that period of time. For early identification to be effective, we cannot wait until we are certain that a long term behavior problem is in the making; we must act at the first signs of difficulties. Action is necessary not only to protect the child, but also to reduce the possibilities of his contaminating the behavior of other pupils.

One place where the analogy between body fevers and "emotional fevers" breaks down is at the point where we decide what action to take. Most often the action taken in the case of bodily fevers is isolation from contact with others because of possible infection. During the isolation period the child may be relieved of a stressful situation and be better behaved temporarily when he returns to class. But isolation by itself may not provide the therapeutic ingredients which will make his adjustment better when he returns to his classmates. The action needed in the case of "emotional fevers" lies primarily in modifying the environment of the pupil. With the new impact of the changed environment can come new responses, and perhaps the acquisition of new ways of behaving in future similar situations.

A basic assumption in early identification, then, is that if a child with a developing emotional difficulty can be detected early, he can be helped most effectively. In addition, as Bower(14) points out, we assume that the developing emotional difficulty is "visible" to someone else so that the potential problem behavior can be observed and interventions can be made. Both these assumptions necessarily include the concept that what constitutes maladaptive behavior in one situation may be considered perfectly adaptive behavior in another; therefore, along with the visibility of behavior must go some normative information for interpreting the significance of the observed behavior in a particular situation.

The test of the validity of early identification must be made by a comparison of the effectiveness of the procedures in selecting children who are subsequently judged to have real problems of a temporary or relatively permanent nature. As in the case of an insignificant fever, over-identification or "false positives" can be tolerated since subsequent diagnosis can rule out pupils with no diagnosable difficulties, but "false negatives" cannot be tolerated since no children with difficulties should be omitted from the list of those identified.

The procedures for early identification also require two steps. The first step is a screening phase which uses readily available information to locate those children who are likely to have some emotional or adjustment difficulty. Once this population of children is identified, the diagnostic phase or second step is necessary to confirm and describe the nature of the child's difficulties or reject the screening hypothesis that the child has real problems of either a permanent or temporary nature. Following the two step identification process, clinicians and educators must collaborate to determine what services and programs should be provided for the identified pupils. The screening phase of the early identification program is analagous to the vision screening program carried out in most schools which uses the Snellen Chart and the Plus Spheres Test to locate from the general school population those children with potential eye difficulties. The nurse does the screening and all children screened are referred to private physicians for the diagnostic follow-up. The screening procedures studied in this project are an attempt to develop a "Snellen Chart" and "Plus Spheres Test" to be used by the classroom teacher in locating children with potential emotional difficulties which will handicap them from profiting from school.

C. Previous Research on School Screening Procedures for Early Identification of Emotionally Handicapped Children

Early identification of potential emotional problems can be accomplished by a number of professional workers. For example, obstetricians are aware of the fact that certain pre-natal and birth conditions are related to susceptibility to personality difficulties. Premature births and brain injuries also relate to the possibility of a child developing emotional problems which in turn are often related to poor school adjustment. Most workers in this field of investigation caution over-interpretation of pregnancy and birth conditions since the resultant behavior of the child is a function not only of the possible biologic damage itself, but is dependent upon the child's psychological defense patterns and upon the environmental forces acting upon him.

Pediatricians have become more aware of the fact that deviations in the developmental pattern of a child may be a warning signal of further danger to the child's normal development later on. With his close relation to the mothers of his patients, he is in an opportune position to counsel the mother toward such goals as less protectiveness, less rejection, more empathy, and an awareness of possible school problems. Pediatricians, too, have a role to play in early identification of emotional problems.

However, since nearly all children go to school, schools have been identified by many as the most important single agency for early identification. A great deal of research has been done which shows that a variety of approaches to the problem of early identification can be effective in locating children who are vulnerable to difficulties. Most of the early identification procedures are designed to be used prior to school entrance and a few in regular classrooms of children who are already in the school grade sequence. Some of them are primarily teacher rating or teacher nomination procedures. Others are involved with standardized parent interviews. Still others use psychological tests and at least one program uses a mental health team approach. All of these methods have been shown to have some validity for the purpose for which they were designed - that of identifying early, potential emotional problems in children. However, the validity of a parent interview is determined in some cases by teacher judgments of behavior, and the validity of teacher ratings used as a screening device is determined in another case by psychiatric interviews of the children.

There is at present no clear cut validity criterion for the evaluation of early identification procedures. Those who developed them had to rely on one or the other of the commonly accepted research definitions of mental health and mental illness. Scott (115) reviewed research definitions of mental health and classified them into the following categories: Mental illness is defined by 1) being in psychiatric treatment; 2) being rated as maladjusted by the community or by a group; 3) receiving a psychiatric diagnosis of a classified type of psychological abnormality; 4) subjectively describing lack of feelings of well-being; 5) listing the number of observable psychological symptoms either on a self-rating form or from the observations of another person; and 6) defining the absence of mental illness by a positive striving. Obviously if a single identification instrument were validated against all of these criteria, six different estimates of its validity would be possible. The validity problems in research of this type are immense. Since we are interested in both temporary problems which need immediate assistance to prevent them from becoming worse, as well as problems of long-term duration, the criterion for mental health or emotional handicaps must be on a continuum and movements of persons classified within this continuum must be expected. Regardless of the difficulties involved in measuring the validity of an early identification procedure, support and encouragement must be given for research efforts in this general area of prevention of mental disorders in children.

Some of the types of early identification procedures for use in pre-school or elementary school settings are described below:

Pre - school Screening Procedures

McKeown (89) describes a project conducted by the Sumter Community Mental Health Project and the South Caroline Mental Health Commission. This approach utilized a mental health team located in a school administration building to screen from children about to enter kindergarten those who might have difficulty making this transition from home to school. Social workers interviewed parents and the psychologist observed the child in a play room. The following week the social worker interpreted the findings to the parent. Immediately following the interviews, the team members conferred and reached agreement on a five point scale which classified the child according to adjustment potential. Sociological factors such as age, sex, family size, father's occupation, mother's occupation (if working), duration of residence in the community and birth order are to be evaluated against the future adjustment of the child in school. Psychological measures including mental age, screening score, and an early edition of the Behavior Rating of Pupils which is used in this project (19), repeated each year. Their initial findings, after a first year of research, indicate that the screening score is highly correlated with both the first and second teacher ratings and that there is a relationship between it and birth order and size of the family - first born children tend to be more maladjusted and children with more sibs tend to have better adjustment ratings.

Lindemann (81) used a similar procedure involving both mothers and pre-school children in an hour interview setting. The mother was interviewed by a social worker and the child was observed in a play room. They interviewed only those parents who volunteered for the program so little information is available on those mothers and children who did not take advantage of the service. Nevertheless, the socio-economic status of the families who sought the service are similar to those of the general population. The best predictor from the pre-school screening program was the agreement of the mother with the child examiner as to the presence or absence of problems. Anxious concern by the mother, not confirmed by examination of the child, predicted poor adjustment in school.

Glidewell (45) reports on a number of studies and follow-ups of parent interviews in St. Louis which gathered data later correlated with school adjustment. He found that the number of symptoms characteristic of the child and noted by parents was highly correlated with teacher rating of school adjustment. A careful study of maternal attitudes and adjustment of school children as measured by teachers showed little relationship between specific attitudes and adjustment, but a significant relationship between patterns or combinations of attitude and adjustment. The mothers with the best adjusted children could see multiple influences on behavior, they felt themselves to be one of the influences and they felt potent to excercise their influence over their children.

This brief review of three approaches to the use of a parent interview as a means of screening potential emotional problems in children suggests that parents can provide useful predictive information for screening which can be later validated against classroom teacher ratings of the children's behavior. The disadvantage to these methods would appear to be the fact that they are very time-consuming and would be relatively uneconomical as compared to other possible procedures.

The Use of Psychological Tests as Screening Procedures

Koppitz (69) has studied elementary school children's performance on the Bender Visual Motor Gestalt Test (11). Using a scoring system on which she has normative data for children of this age, she found that out of 119 children referred to a guidance clinic because of emotional and behavior problems, 83 did poorly on the Bender. Using cut-off scores on Benders administered individually to children in the beginning elementary grades, she postulates that the vulnerability of the child to school stress will be manifest in poor performance on the Bender. The Bender score is then compared to intellectual potential as measured by an intelligence test, and the environment of the child. While she has not yet developed a procedure for combining these three sources of data, she suggests that the emotionally disturbed child will show up with a combination of low ratings on each of these variables.

The Division of Mental Hygiene of the Alabama Health Department conducted a screening program in three rural counties. McKee (88) reports that the purpose of this program was to identify the nature and extent of specific mental health problems, to establish programs of prevention and to integrate this new program into the total health services offered by the State Department of Public Health. For this purpose they started with psychological screening which used the Vocabulary Test of the Wechsler Intelligence Scale for Children (134), a perceptual achievement test, the Lee-Clark Reading Readiness Test (79), Sub-tests 3 and 4, an adaptation of the Gesell Development Scale (42) and a social emotional rating scale. From the results of these tests a mental health record for the first school year of the child was developed. Children who did not meet the minimum levels set by pre-determined cut-off points on the tests were re-scheduled for complete psychological evaluation, resulting in either referral to a mental health resource, follow-up in the home by a public health nurse, or a "clean bill of health." Teacher ratings and observations were then gathered on the sample of children tested in order to validate the screening procedure. Parents were asked to rate their children on a rating scale similar to the teachers'. The first analysis of these data suggests that the psychological rating used in the screening process has considerable value in predicting teacher ratings of children during the first school year.

Smith (123) used six group-administered personality and adjustment tests for children. He concluded that none of the tests discriminated well enough for individual predictions. However, he noted that several of the tests had group differences large enough to make them applicable for limited predictions when other test data were combined with this information.

The Use of Teacher Ratings as a Screening Procedure

Ullman (130) surveyed the nature and extent of the mental health problems presented by a group of children in the ninth grade of a public school system. He was also interested in finding out to what extent the judgments of teachers identified children who needed psychological assistance. He found a high correlation between the judgments of teachers and clinicians, and concluded that teachers and clinicians are in greater agreement in their judgments of the behavior problems of children than originally thought.

Cooper (31) also used classroom observation by the teacher as a screening procedure. He developed an Observation Check List which required the teacher to mark 37 items of behavior as present or absent in each child. Of the total group studied, 30 were selected at random for psychiatric examination. The psychiatrist, too, had an interview check list on which he recorded the child's behavior during the interview. Following the visit with the child, the psychiatrist made inferences on a rating scale about the child's behavior from his observations. Using the "pathology" rating from the psychiatric interview as the criterion, Cooper designated a cut-off score from the teacher observations which would most efficiently identify those pupils whom the psychiatrist saw as needing help.

Summary of Previous Research

Even though the research presented previously makes no claims for the ultimate validity of the screening devices studies, there are enough positive findings to indicate that a screening procedure can be developed as part of a program of early identification of emotionally handicapped children. The summary of these screening procedures points out that reliability and validity criteria are lacking. Most of the validity studies have used teacher ratings of school adjustment as the criterion. This is only one of the six types of criterion measures suggested by Scott. Cooper's work was validated against psychiatric assessments, another of Scott's criteria. Nevertheless, we have no information about how these validity criteria are different or how they are similar. The use of the above screening procedures can classify each member of a group of children as adjusted or maladjusted, but are not designed to provide a score on a continuum of mental health status. Lastly, each should be evaluated from the standpoint of the breadth of the population which is reached by the method as well as the economy of effort in making the screening judgments.

Previous Research on Early Identification by the California State Department of Education

1. The 1955 Study

The first study (12) of a procedure for early identification of emotionally handicapped children consisted of an examination of school records of pupils who had been diagnosed as emotionally disturbed in child guidance clinics, school guidance clinics or by private practitioners. In addition, teachers who had the emotionally disturbed pupils in their classes were asked to complete a teacher rating on every pupil in the class and to administer a peer rating and a self rating to all pupils. The results of this study showed that:

a. Emotionally disturbed children scored significantly lower on group intelligence tests. On psychological tests given individually, they approached the mean of all children included in the study.

b. Emotionally disturbed children scored significantly lower on reading and arithmetic achievement tests. The differences were greater and more significant on arithmetic achievement. The higher the school grade the greater these differences became.

c. Emotionally disturbed children differed significantly from other children in their classes in their self-perception as revealed in some of the items on a self rating. Emotionally disturbed boys exhibited greater dissatisfaction with self and their school behavior than the other boys. Emotionally disturbed girls showed less dissatisfaction with self than the rest of the girls in the class.

d. On the peer rating administered to the entire class, other children in the classes tended to select emotionally disturbed children for hostile, inadequate, or negative roles and failed to select them for the positive, good roles.

e. Emotionally disturbed children came from homes that were not significantly different in socio-economic level from those of other children generally.

f. Altogether 87 percent of the clinically-known emotionally disturbed children were rated by their classroom teachers as among the most poorly adjusted children in the class. As perceived by teachers, 4.4 percent of all the children in their classes were seen as overly aggressive or defiant most of the time, while 6.1 percent were overly withdrawn or timid most of the time. The clinically known emotionally disturbed children were to be found within these two groups.

An Adjustment Index suggested by these results was computed from a sum of weighted scores from each of the above indices which successfully discriminated the clinically known emotionally disturbed group from their classmates.

2. The 1958 Study

In January 1958, the Department of Education began a research study which was designed to find a means of identifying early children with emotional problems who were attending school. In addition, a primary objective was to evaluate a variety of educational procedures and assess the administrative and financial aspects of each experimental program. This project provided the opportunity to try out the screening materials on a larger population. The objective in this case was to locate children with potential difficulties who had not previously been identified.

About fifty school districts in California participated and over 40,000 children were involved. The screening materials developed in the 1955 project were applicable on elementary age pupils only; thus it was first necessary to develop instruments which could be used with primary grade pupils as well as with those in junior and senior high school. The revised teacher rating was applicable to all grade levels so it was contained in each of the three batteries of tests. Peer ratings and self ratings were revised for the elementary grades. A comparable rationale was used to develop with appropriate format peer and self ratings for the primary and secondary age pupils. The screening process containing a teacher, peer and self rating was administered to all of the pupils in the grade levels where experimental educational programs were to be established. The criteria for screening were to identify for further study any pupil who had two or three of the ratings in the battery within the five most negative scores of all the pupils in his class. Thus some pupils were identified with teacher and peer ratings as negative, some with teacher and self ratings and others with peer and self ratings.

Correlation coefficients were computed comparing the relationship between teacher, peer and self ratings. Each rating appeared to be measuring different aspects of behavior with teacher and peer ratings most highly correlated, and self ratings correlating least with the other two. Test-retest reliabilities were computed and found to be equivalent to the reliabilities of other tests used at the same grade levels (75).

Using the rank order procedures for identification as described above, from 10 to 15 percent of the population screened were identified for further study. From the subsequent diagnosis provided by a psychologist or psychiatrist, validity data were supplied to further analyze the effectiveness of the three ratings as a means of preliminary identification of emotionally handicapped children. The findings from the second application of the screening procedure are as follows:

a. Clinicians agreed on subsequent examination that 90 percent of the pupils surveyed by the screening procedures and selected on the rank order procedures described previously could be considered children with real problems needing some type of help in school or in a mental health facility. (13)

b. The screening process was found to identify a variety of pupil problems. About equal numbers were identified as having either withdrawn or aggressive behavior while fewer were classified as eccentric and bizarre. (75)

c. Those children who were screened were found to have significantly lower school achievement in reading and arithmetic as well as significantly lower group intelligence test scores. (17)

d. The children screened in this study were found to come from socio-economic levels predominantly in the semi-skilled and unskilled working population suggesting that socio-economic status is a factor even though it was not significant in the earlier study. (17)

e. Item analysis of all the screening materials - teacher, peer and self ratings - indicated that the items could successfully differentiate the pupils screened as emotionally handicapped from the general school population of that grade. (75)

f. A blind study (75) of 30 pairs of pupils matched for sex and grade, but with one member of the pair screened as emotionally handicapped and the other judged to have good school adjustment, showed that clinical psychologists could select on the basis of testing and observation 9 out of 10 pupils screened by the identification process.

In addition to these findings regarding the screening process, a definition of the term "emotionally handicapped" as described previously was developed and a suggested procedure for early identification of emotionally handicapped pupils which contained both a screening and a diagnostic phase was recommended. (17) (20)

3. The Present Research Instruments

On the basis of the research findings described above, all of the screening instruments used in the 1958 research study were revised and submitted to the Office of Special Tests of Educational Testing Service, Princeton, New Jersey. Educational Testing Service provides the opportunity for those who have developed measurement instruments of promise to submit them for review. If they meet their criteria, they are edited and printed by ETS for distribution to qualified research workers for further study in other parts of the country. Such an opportunity as this provided the authors of the tests with the chance to have expert review of the materials and to have others try out the screening process, and determine its usefulness before making any further moves toward broader use of the materials. Three batteries of screening materials are available - one for primary, one for elementary and one for secondary grades. Each contains a teacher rating, peer rating and self rating. In addition to the ratings are accessory materials including a Teacher's Manual (20) and Technical Report (75), Class Record sheets and scoring forms.

The screening process developed by the California State Department of Education and printed and distributed by Educational Testing Service is the material used in this research study. In general terms, the ratings used in this project are described as follows:

a. Behavior Rating of Pupils (19) - Teacher Rating

The teacher rating contains eight statements of pupil behavior which can be rated on a 7-point continuum indicating the best to poorest school adjustment. A modification of a Q sort procedure in which the teacher must place every member of his class in some spot in a normal distribution makes possible a good distribution of pupils on each trait and better discrimination power than a simple "either-or" type of rating procedure. The same rating is used for all grade levels.

b. The Class Pictures (21) - Peer Rating for the Primary Grades

This instrument consists of pictures of pupils in which there are depicted many different kinds of child behavior - positive, negative and neutral. Each student is asked to indicate which of his classmates he associates with each kind of behavior. The frequency with which each student is mentioned by his peers in association with positive and negative behavior roles is the prime information used in applying the results to the screening process.

c. A Class Play (23) - Peer Rating for Elementary Grades

The rationale used to develop the Class Pictures dictates the development of the Class Play. The difference in the two instruments lies in the fact that the Class Play contains written statements of behavior and the Class Pictures are drawing of children requiring no reading of test items.

d. A Picture Game (18) - Self Rating for the Primary Grades

Thus far the self rating instruments have been the weakest predictors of other criteria of school adjustment. They continue to be included in the battery until a better determination of their validity can be made. The Picture Game consists of 66 pictures, including two sample pictures. Each picture is illustrative of normal home and school relationships and events. With the exception of the two sample cards and the first ten pictures, each picture is emotionally neutral in the portrayal of the relationship of event. The child is asked to sort each picture into one of two categories: "This is a happy picture." or "This is a sad picture." This self rating is scored simply by checking to see if the child understood the instructions, and then counting all the cards in the "happy" side of the box into which he has sorted all of the cards.

e. Thinking About Yourself (22) - Self Rating for Elementary Grades

This rating aims at obtaining an intra-self measure relating "perceived self" to "wanted" or "desired" self. Each item contains a statement briefly descriptive of a boy or girl followed by two questions: "Are you like him?" and "Do you want to be like him?" The pupil's answer can vary along a scale from "Not at all" to "Very much." The test is scored by computing the amount of difference between the answers to the two questions, thereby getting a measure of the "distance" between "perceived" and "wanted" self on each item and then summing these discrepancies for all items.

4. Criteria for Developing a Screening Procedure

The procedures for administering and evaluating the screening process are found in the Manual and Technical Report. At the conclusion of six years of developmental work on a procedure for early identification and a review of the work of others, Bower and Lambert propose a list of criteria for judging the usability of a screening procedure. In order for screening instruments and methods to be widely useful as well as effective in screening children with emotional handicaps in the school, certain operational conditions are set forth for their development. These operational conditions are as follows:

a. The information to be collected by the teacher should be usable with large samples of school children and the instruments used should be capable of group administration.

b. The collection of the data should not involve as a necessary condition direct psychological or psychiatric assessments.

c. The administration and scoring of rating scales and tests should require a minimum amount of time and work.

d. The data should be obtainable as part of regular classroom routine and not involve the teacher in extra classroom duties, home visits, or individual test administration.

e. The data collected should help the teacher obtain a comprehensive picture of the child from as many sources as would be economically possible.

f. The data collected should not offend parents or involve questions of a highly personal nature to parents or children.

g. The major function of the data collected and the process utilized in obtaining the data should be one of screening, not diagnosis.

h. As a result of utilizing such a screening process, however, more positive and earlier referrals of children in need of help would be made.

i. As a consequence of the use of the screening process, teachers would develop a higher degree of commitment to action on behalf of screened children.

E. The Community Climate in Which This Research Project Was Carried Out

In August 1961 when Project 1186 began officially, the Southern California community had been subjected to a bombardment of public speakers and articles in newspapers and magazines linking the effort to identify and help children and adults with mental health problems to ever-increasing danger of communist infiltration for the purposes of subversive activity. The major theme of these attacks on community mental health programs was that they sanctioned an invasion of personal privacy which in the long run would do harm to the individual because giving information about himself would make him vulnerable to the appeal of subversive ideologies. There is manifest content in this objection available from the prisoner of war records of American prisoners in Korea (61).

Many of those fighting community mental health programs had had prior experience in anti-vivisection programs and the fight against fluoridation of water. However, of concern to us here is the fact that this anti-mental health movement received support from a fair porportion of parents in schools who had previously approved of school guidance programs in which a variety of group and individual assessment procedures were used for the purposes of educational planning.

The importance of such attacks on school and community programs involving mental health problems is that they bring into focus the necessity for reviewing the procedures used to inform the public about existing programs, as well as for insuring the fact that continuing community sanction for the school guidance program is available. Since this project was designed to involve a large number of children with and without learning and behavior problems, the issues in these attacks needed careful review and ways of securing parent support had to be found.

In 1959 Nettler (97), in conducting a community-wide psychological research program, found that the program could not continue because of community misinformation about the value and use of psychometry. She concluded that the behavioral scientist who wishes to use portions of the community for a research program cannot assume that his scientifically honorable intentions will be considered morally justifiable by those whom he seeks to help. The scientist must anticipate such societal conflicts and plan to reduce or minimize their effects if he is to succeed in his efforts.

Eron and Walder ran into difficulties similar to those of Nettler's in a small city in the State of New York. Their research problem was on mental health in rural areas and focused specifically on the development of aggression in children. A detailed account (36) of their experiences is not important here; however, their review of some of the factors which enabled them to complete their study is worthy of note. They cite as some factors influencing the successful conclusion of their project: integrating the research workers as members of the community, careful planning and gradual introduction of each phase of the project with community sanction, providing well-trained and acceptable interviewers, reducing the amount of psychological jargon in public communication, and avoiding sensationalism in the use of statistics and research findings in the press.

Generalizations about opposition to community mental health programs are risky. Marmor, Bernard and Ottenberg (85), in their discussion of the psychodynamics of group opposition to health programs, point out that this opposition covers a wide range of heterogeneity " .... from groups whose opposition is based on science and reason, to those whose objections appear to be based on self aggrandizement or political considerations, and finally to those whose opposition stems from irrational anxieties or ignorance." Regardless of the sources of the opposition, the successful completion of a research endeavor in this field must take them all into consideration and plan the introduction and execution of the study so as to maximize the possibilities for concluding the study without event.

For this project important considerations were: Obtaining sanction and support of the school administrator and teachers assigned to the project; developing a means for communicating with parents which involved a minimum of language with uncommon understanding; securing sanction from the parents of children in the project for each phase in which the child would be involved; and having the research staff available to the school at any time for help in interpreting the program.

Chapter III - THE OBJECTIVES OF THIS PROJECT

A. The Problem

The research problem is one of validating instruments which have shown promise for effectively and economically tapping teacher, peer and self perceptions in the primary and elementary grade levels. The instruments are those described in Chapter II which have been developed in previous studies and have been shown to be capable of efficiently and reliably screening children with emotional problems. A screening program along with a subsequent diagnostic follow-up are the two steps in a recommended procedure for early identification of emotionally handicapped children discussed previously in this report.

B. Research Hypotheses

The hypotheses relevant to this research proposal are as follows:

1. Children with mild or moderate emotional handicaps can be economically and effectively identified by the use of a screening process.
2. Such a process can be economically utilized by an entire school system.
3. Screening instruments can be developed which individually and collectively meet the reliability and validity standards for such measurement.
4. The use of the "perceptual triad" (teacher, peer and self) in the screening process will identify children with similar degrees of emotional problems but with a wide variety of behavior manifestations. In addition, the use of the screening process will provide a more effective and comprehensive plan of screening than teacher or parent referral.
5. The screening instruments can be combined into an Index of Alienation or Relatability which will be useful in measuring change in the mental health status of children as related to specific programs provided by schools such as parent counseling, mental health consultation to teachers, in-service programs, special classes, etc.

Related hypotheses which will be tested in future studies are:

1. Teachers using the instruments and process will make a significantly greater number of early referrals than they would without the assistance of this screening procedure.
2. Teachers using the instruments and process will relate in a more positive manner to guidance and psychological staff and to the referred child.
3. Participation in the screening process will help the teacher become a more effective inquirer into the validity of his perceptions of children.

C. Procedure

Project 1186 has three phases. The first phase was the establishment of criterion groups of children at second and fifth grades. These groups were selected to represent children with few, if any, problems in school as well as those who were experiencing some difficulty. The second phase was the administration of the screening materials and the third and final phase was the comparison of data collected on the screening materials with data from the establishing of criterion groups. A more detailed description is as follows:

1. Phase One

   a. Step 1. Orientation of clinical teams. Psychiatrists, clinical psychologists and social workers were chosen and then met as a total group to review related research. Their discussion was focused on the predictive value of information collected in their professional disciplines in order to include the most useful data in their standardized interview schedules. A standard social work interview schedule was developed; a psychological testing schedule, and an observational check list was prepared for the clinical psychologist; and the objects in the play kit, procedures for their interview of the child and the check list of observations were established for the psychiatrists.

   b. Step 2. Selection of schools to participate in the project.

   c. Step 3. Training teachers to observe and rate behavior.

   d. Step 4. Pooling of previous year's teachers, school principal and school nurse observations of present second and fifth grade students.

   e. Step 5. Sampling of pooled observations to select a representative group of children from second and fifth grades for evaluation by social worker, clinical psychologist and psychiatrist.

   f. Step 6. Assessment of pupils by clinical team.

      1) Social workers scheduled home visits of pupils selected. The responsibility of the social worker was to explain to the parents the purpose of the research study and to obtain permission from the parents for psychological testing and interviewing by a clinical psychologist and a psychiatrist. If the parents agreed to participate in the project, the social worker gathered pertinent information from the parents about the child's development and current school adjustment. Since a variety of children became part of this study group, there was no special stigma applied to the child or the parents for their participation. The parents were told when they inquired, that their child was selected at random from the general school population for further study.

         If the parents did not wish to participate, the social worker concluded the interview with no further comment.

      2) After the parents gave permission to have their child studied, a clinical psychologist and child psychiatrist experienced in working with school children made appointments with the school for testing and interviewing the children during the school day using standard procedures.

      3) The quantitative and qualitative data collected by the clinicians were gathered in pre-arranged schedules for further analysis and later compared to the results in Phase Two.

   g. Step 7. Compilation of existing school history from cumulative folders of all second and fifth grade children.

   h. Step 8. Establishing criterion scores of school adjustment status for the project pupils selected in Step 5.

2. Phase Two

   a. Parents of all the children in the second and fifth grades where the random group of children who received complete evaluations were enrolled, were informed by mail from the school that their children were to participate in a screening program designed to locate those children who are having or will be having some difficulty in school. If they did not wish their child to participate in the screening, they were able to request that their child be omitted from the screening program.

   b. Teachers of second and fifth grades who were to administer the screening materials met to review the procedure for screening and to obtain the materials which they would use.

   c. Screening materials were administered and scored by the teachers or project staff.

   d. If additional testing was necessary to collect achievement and ability information for the children in the screening phase, the tests were provided by the project and scored by project staff. A teacher could administer such tests, if they were needed, to his own class if he chose to do so.

3. Concluding Phase

   Materials collected in Phase One and Phase Two were analyzed statistically and the results were combined into a statement of the validity of the screening process for identifying children with learning and behavior problems. The screening materials were studied individually and collectively for their value in predicting children with identifiable problems.

From the above procedures the research hypotheses of this project were tested. The following material describes in detail the procedures used to identify a criterion group of pupils against which to study the validity of the screening instruments developed to identify children with emotional handicaps in the primary and elementary grades.

Chapter IV

SELECTION OF THE SCHOOLS TO PARTICIPATE IN THE PROJECT AND THE DEVELOPMENT OF COMMUNICATION MEDIA FOR THE PROJECT

A. The Problem of Conducting Research in Public School Settings

With the increasing emphasis on scientific investigations of all types, including those in the behavioral sciences, interest in and respect for the results of educational research activities is increasing also. Most educators regularly review research material for findings which might be pertinent to their own programs, but they must rely on the efforts of others for the conduct of specific research activities. A research worker hoping for the help of a school or school district in his research study must be aware of some of the limitations of the school setting as he plans and conducts his study. First of all, single variable research and carefully controlled experimental conditions are difficult if not impossible to obtain. Secondly, attrition of pupils from the beginning of the study to the end of it is common. In addition, teachers may have schedules which conflict with the management of the research and often may not have time available to devote their maximum or optimum effort to the research job at hand. The research worker must recognize that no matter how important the work is to his own field, educators may not be similarly aware of its value and may perceive the entire operation as a huge interference with their ongoing educational activities . All of these findings may occur in any school situation in spite of the interest of the administrators or teachers in the value of research in general or the value of the research study in question.

Since the public elementary school, like the lower division college classes, offers an ideal opportunity to collect data on a number of subjects with a minimum amount of effort on the researcher's part, schools are often deluged with research plans in which someone is asking them to participate. Most school districts have an established protocol which must be followed in order to gain approval for a study. One must review this procedure, and establish check points to see if it is followed as the work progresses. Approval for the conduct of the study goes beyond the approval of the chief administrator. Teachers often feel they are "volunteered" for extra work so that obtaining and maintaining their cooperation is a pre-requisite for the successful outcome of research activities. It is not going too far to re-state again that research activities interrupt school programs and make demands on teachers which may cause them to resist participation and limit their cooperation.

Such a climate in the schools is a reality for all of those who work there. Most of these obstacles to completing research studies can be met and overcome by careful preplanning and effective communication and feed-back. The steps are fairly simple and are defined by identifying critical problems in the administration of the research study such as: selecting a school which would be interested in the particular study, identifying potential resistance by the parents or community to the research activities, selecting a person on the school campus as the communication contact, initiating and maintaining teacher involvement in the project, preparing research schedules which detail the specific steps of the study, the number of people who will be involved and the time it will take them, minimizing after-school teacher time, and providing assistance for all the clerical tasks which the project demands.

B. Selecting the Schools for Study

In this project schools in the Greater Metropolitan Area of Los Angeles were the target for the research project. The reason for this specifically relates to the availability of clinical personnel necessary for the establishment of the criterion groups. The clinicians' available time for such a study could be anticipated as being limited;

therefore extensive travel to schools far beyond the locale of their offices would be impossible. School districts were first reviewed and ranked on the basis of their previously indicated interest in the object of the research program of this type and then compared with the potential source of clinical personnel within a half hour's driving time from office to school.

School superintendents were then contacted by letter with a brief statement of the project outline, the expectancies for teacher and staff involvement, the advantages accruing to the school and district for participation, and the cost to the district beyond the time of related school personnel. Those districts which replied to the request to consider participation in the project were then contacted in person by the project director.

The school superintendent or his delegate is in a good position to compare a given school within his district with the project goals and then to determine which principals, teachers and staff members are likely candidates for the project. During the conference with the superintendent, the schools were selected for the study and individual appointments were made subsequently with each principal at his school to discuss with him the project goals and the expected extent of his and the school's involvement. The choice of schools by the superintendent was so good that no principal interviewed declined to participate.

Seven schools were selected within the Los Angeles City School District, two in the Claremont School District and two schools within the La Vista School District in Hayward. The latter schools, lying south of Oakland, were selected because the superintendent had made a personal inquiry about the possibility of being involved in the project and clinical personnel were available who could schedule time for the evaluations. The eleven schools which participated in the project were selected by subjective rather than random sample procedures; however, every effort was made to pick schools not characterized by specific socio-economic or environmental factors which would have biased the results beyond usability. In order to deal with variables which could be later found to be related to the research findings, all available information on socio-economic, intellectual and health factors were recorded and evaluated in the results of the project. The classrooms and teachers are considered to be typical of those found in California in suburban or urban communities. The schools are distinguished by the fact that the principals were specially interested in the problems of pupils who were vulnerable to school difficulty, but this factor is considered to be an advantage to the conduct of the project rather than a biasing factor.

C. Establishing Channels of Communication

In most schools the principal is the chief contact for all communication from the school district office and the community; however, in some districts, another person such as the school psychologist may be designated as responsible for the conduct of a research project and it is he who then makes arrangements for the research workers. In any case, the decision for the procedures to be handled in making schedules of teachers' meetings and testing rests with some designated person, usually the school principal. All information about the project was sent directly to the principal or other designated person. Occasionally, copies of material sent to principals were sent to the superintendent in order that he could be informed of the progress of the project in case inquiries came to his office instead of to a participating school. Some of the specific techniques of communication used in this project are as follows:

1. The Information Release

At the time this project was initiated, many parents and community members had been subjected to a good deal of unfavorable publicity about the ulterior purpose of programs for pupils with emotional handicaps and the suspicion that many types of psychological tests and psychiatric procedures were subversive in nature and intent. The project staff anticipated the contaminating effect of such publicity and decided to prepare an Information Release which stated the goals of the project in simplest terms. This Information Release was prepared to be used by all principals, teachers and clinicians as the reply to any question about the nature of the project. A copy of it can be found in the Appendix (page 2). One should note that the information release does not make specific use of such terms as psychological testing, mental health screening, emotional disturbance and so forth. These terms were not used because of the belief that they do not communicate the real purpose of school programs, focused either on identification or education, to assist children with emotional difficulties. Most parents understand easily the problem of the pupil with learning difficulties. And too, most parents have had some contact with children with behavior problems of a variety of types. They know that such youngsters can have a difficult time in school, and it is not uncommon to find a parent who has known of a particular child committed either to the courts or to other institutional placement. As a result of these experiences with children, most people understand the role of the school in assisting the child with learning and behavior difficulties, but few of these people can grasp the role of the school in assisting with something as nebulous as "emotional problems" since this seems to be an invasion of privacy in a personal area which lies in the domain of the family.

Another objective directed the writing of the Information Release. The project design requires that clinicians determine from a sample of the school population, without prior information on the adjustment status of the pupils, those children with adjustment difficulties (emotionally handicapped). The sample which they evaluated contained children from all parts of the pupil population, the best-adjusted to the poorest. It was important, therefore, to keep information about the project focused on the goal of finding out something about children with problems, how they were different from children without problems, and finally how to identify them so the school could provide assistance early enough to do some good. Copies of the Information Release were made available to all teachers in the school who were interested in the project, to the principal, the school secretary, the guidance and nursing staff and the superintendent's office. In addition, the Information Release was given to every clinician to use in his explanations in home visits or to paraphrase for use with the pupils who were evaluated at school. In this way information given on the project was consistent and no negative community or parent reaction occurred.

2. A Summary of Project Goals

In addition to the Information Release, a brief statement of the project design was prepared for the principal and school administrators who were to have administrative responsibilities for the project. The purpose of this summary was to provide a ready reference in simple form in case there was a need to compare any aspect of the project with the ongoing activities in their school. The project application was too unwieldy for such a purpose, so the material from it was re-written into a briefer, more readable form. This summary was also given to all clinicians in order that they would have a chance to keep track of the steps in the project as they worked along during the school year.

3. A Calendar of Research Activities

Since some phase of the project was likely to be in operation during the entire school year, a calendar of all events was prepared initially for each school principal. This calendar contained not only the approximate dates during which some aspect of the project was to occur, but listed all of the details for which the principal was responsible. At the end of the Fall semester in January, those activities which still remained were again summarized and specific dates for remaining teacher meetings, testing, scoring and summarizing were scheduled. This process of regular channeling of project activities to the principal made it possible for us to have at the time of the project's close all of the materials which were needed. In addition, it provided the advantage of allowing the teachers the maximum amount of time to arrange their programs in order to plan to include the testing and ratings in classroom activities where they fit best. There were no surprises then, since all steps were carefully outlined. The school selected the dates for each phase which involved their direct participation, and advance notice was provided for all project requirements.

4. Anticipating Teacher Work Load

Many clerical tasks, including test scoring, are among those activities which are now done by clerks instead of the school faculty. A project such as this one is apt to require additional teacher time to administer and score tests, to nominate and rate pupils and to prepare class lists for a check of correct spelling and omissions of specific data. In order to minimize the extra time teachers would be asked to work, beyond test administration and pupil ratings, graduate students were employed to assist in classrooms where teachers needed help and also to collect all pupil data from cumulative record files. Test scoring was provided by the project office for any teacher who did not wish to complete his own tests. These procedures greatly reduced teacher time, and added to the successful completion of the project by insuring more complete cooperation from the school staff. In spite of such provisions, however, teachers, principals and school clerks found themselves much more involved than anticipated with each phase of the project and it is a tribute to their professional standards that they completed all requirements on schedule and met each of the demands with a minimum of resistance. Without such good cooperation, research such as this could not be completed.

Chapter V

SELECTION OF THE PUPIL SAMPLE TO ESTABLISH THE CRITERION GROUPS

No ready-made list of pupils with or without school difficulties is available in schools. This fact makes selecting a sample of pupils from a continuum of school adjustment problems extremely difficult. Even though a list of referrals to the school guidance office is available, it has limited use. This is principally because many selective factors cause a teacher to refer a pupil and these factors vary from teacher to teacher. Asking teachers to nominate those pupils with distinct adjustment difficulties in school is a somewhat better method of obtaining a criterion group; nevertheless in this regard also, teachers vary in the degree to which they take note of certain pupil behaviors so that little consistency can be expected from teacher to teacher. Teacher monimations therefore, will not include all those pupils with possible emotional handicaps; but on the other hand, the pupils the teacher nominates no doubt have noticeable difficulties.

Tests of personality also have limited use as criterion measures for the purposes of this project since they most typically provide scores describing behavior dynamics or areas of personality motivation, but are limited in providing a meaningful over-all score of pupil adjustment. As mentioned previously, Smith (123) studied the validity of six group personality adjustive measures of children. She concluded that none of the tests discriminated well enough to be used singly. However, he noted that several of the tests indicated group differences large enough to allow for a limited degree of applicability when combined with other measures. In Ullman's study of teacher, peer and self ratings (130) he showed that the personality inventory had the lowest predictive value when compared to teacher and peer ratings, but that it did add a significant dimension to the total appraisal process. Jackson's correlations of teacher observation, group personality tests and sociometric ratios (57) indicate that each of these types of scores is measuring different aspects of pupil behavior.

The problem for this research project in selecting the pupil sample was 1) to find some means of tapping the day-to-day observation of teachers so that a rating of school adjustment could be made of each member of the class, and still not contaminate the teacher rating which was to be evaluated as one of the screening procedures; and then 2) to take a sample of this adjustment status at random so that these pupils could subsequently be evaluated independently by the clinical team.

The teachers who had had the pupils enrolled in the second and fifth grades in the Fall of 1961 as first and fourth graders participated in this first phase of the project. Their job was to attend the training sessions where they were trained to observe and rate children's behavior on a continuum from good to poor school adjustment. By involving these teachers instead of the second and fifth grade teachers who would be administering the screening materials later in the Spring of the school year, the contamination of training sessions on the Behavior Rating of Pupils (the teacher rating used in the screening process) could be avoided. The teachers who would administer the screening materials were not involved in the selection of the criterion group and thereby could be considered typical of those teachers who would use the screening process in any school situation. If the screening process were tied in with training sessions in this validity study, the later use of the screening materials would have to follow similar training sessions. This would complicate a screening program and add to expense of screening, the cost of the mental health consultant for the training sessions.

One weak point in this procedure is that the school adjustment of pupils is not a static affair. Some pupils identified as having difficulties at the end of a school year might not have as serious problems in the next grade. Nevertheless, since the purpose of the original teacher rating was to get a score from which a sample could be drawn for the clinical teams to evaluate, such changes in pupil status would be independent of the judgment of the clinician which was made later during the school year. A pupil with emporary severe problems given a high rating by his teacher of the Spring of 1961 would ot necessarily receive a high rating by the clinical team in the Winter and Spring of 962. The correlation between the 1961 and 1962 teacher ratings could easily provide ome indication of the stability of pupil's adjustment difficulties from one year to nother. Thus this factor of stability of adjustment status is not considered to be a roblem needing further consideration at this point.

. Training Teachers to Make Ratings and Nominations of School Adjustment Status

The teacher training sessions held in each school provided a common frame of reference for the initial teacher rating. At these sessions the goals of the project were reviewed, the problems of emotionally handicapped children were described and specific types of children were discussed as examples of potential emotional handicaps. Teachers were free to ask any questions they wished about emotionally handicapped pupils and spent some time discussing general behavior problems of pupils whom they thought might fit the classification. The procedure for rating the class members on a scale of school adjustment was then explained and materials summarizing the training sessions and the rating form were left with the teachers at the end of the meeting. A copy of this material can be found in the Appendix (pages 8 - 10).

. Obtaining Teacher Ratings and Principal, Teacher and Nurse Nominations

The model for teacher ratings which was developed by the authors in previous research (75) and used in the Behavior Rating of Pupils was applied to the solution of this rating problem. This model is based on the assumption that school behaviors can be rated on a continuum and that the behavior of a specific problem pupil is not in a discrete class of events.

The teachers were asked to sort out their entire class on a seven point scale of school adjustment using the definition and description provided in the training session material. A ranking of the entire class was then provided with the pupils grouped in seven categories, roughly in a normal distribution. In addition to this rating, each teacher was asked to review the class roster noting any pupils with consistently poor adjustment. Those that were discovered at this point were nominated by the teacher and classed under one or more of the five following behavior descriptions of emotionally handicapped pupils:

1. An inability to learn which cannot be adequately explained by intellectual, neurophysiological or general health factors.
2. An inability to build or maintain satisfactory interpersonal relationships with peers and adults.
3. Inappropriate or immature types of behavior or feelings under normal circumstances.
4. A general pervasive mood of unhappiness or depression.
5. A tendency to develop physical symptoms, such as speech problems, pains or fears associated with personal or school problems.

School principals and nurses were also asked to nominate any pupils from the classes under consideration using a modification of the form presented to the teachers for their ratings and nominations. This same form was used prior to the screening program in the Spring of 1962 to get teacher, principal and nurse nominations of specific pupils before the screening materials were administered. The instructions for principal and nurse nominations can be found in the Appendix (page 11).

At the end of the training sessions, the following data were available: 1) rating of every pupil on a scale from 1 to 7 (good to poor adjustment), and 2) nominations from the teacher, principal or school nurse of specific pupils in the same classrooms with outstanding problem behavior. These materials were used next to stratify the population before selecting the original sample of pupils who would be scheduled for individual study. The distribution of teacher ratings of school adjustment by grade and school can be found on Table I

C. Dividing School Population into Two Groups - Above and Below Average School Adjustment

The grids on which the teachers had made their ratings provided the names of all of the pupils in the class ordered into an approximate normal distribution. Deviations from normalcy came about because once a teacher selected a single pupil for a particular place on the grid, he was to place all other pupils with similar adjustment status in the same column. Peculiarities in class structure would then show up in the skewing of the teacher's ratings to either side of the rating grid. Extreme examples of such skewing were not found. Most teachers found it quite possible to order their class in the squares provided in the rating form since the classes in this project were fairly heterogeneous in regard to school behavior.

Each class was then divided into two groups. One group contained the names of those pupils rated as being in the third of the class with the poorest adjustment. The other group of pupils was comprised of the remainder of the pupils on the class roster. Most pupils in the poorest adjustment group had ratings of 5, 6 or 7, while ratings of 1 to 4 were typical of the second group. Deviations from these ratings occurred only when a pupil was nominated by a teacher, principal or nurse and received a rating of school adjustment lower than five. A few pupils were thus placed in the group of more poorly adjusted students with teacher ratings of 4 or higher plus a nomination from the teacher, principal or nurse. The distribution of teacher ratings for pupils nominated by principals, teachers or nurses can be found on Table II.

D. Randomizing, Stratifying, Sampling and Randomizing the Population

Two lists for each grade were made of the names of pupils in the classes divided into these adjustment categories. Two lists for the second and two lists for the fifth grade were available for each of the 11 schools. The next step was to number the pupils as their names appeared on each of the lists, and then to randomize both lists of names for each grade and in each school. Following this randomizing, the number of boys and girls were tallied in the group designated as being composed of the poorly adjusted pupils. From the randomized list of the better adjusted pupils the number of boys and girls equal to the number of boys and girls in the poorer adjusted population was selected according to their random order. Two lists were finally available, each with the same number of pupils and balanced for equal numbers of boys and girls. The remaining pupils were eliminated at this point. The final step in the preparation of this list was to place the names of both groups, the ones with above and below average in school adjustment, on a single list in random order. This ordering was accomplished according to coin tosses.

E. Establishing the Project List

The project list, therefore, was composed of a random list of names of pupils sampled from the total population in terms of teachers' ratings and nominations of school adjustment with equal numbers of better and poorer adjusted pupils and the same number of boys and girls in each category. In such a procedure the most poorly adjusted pupil may not turn up in the randomizing process close enough to the top of the list so he will be selected for clinical evaluation; however, such a disadvantage is off-set since the sample comes from a continuous distribution and is composed of students typical of those in all parts of the school population at that particular grade level, but weighted to contain the names of more pupils at the poorer adjusted end of the continuum. The stratifying was necessary to make sure that the list for clinical evaluations contained enough pupils with poor school adjustment to make possible adequate item analysis of the screening materials and other school data.

TABLE I

DISTRIBUTION BY GRADE OF ALL TEACHER RATINGS OF PUPIL'S SCHOOL ADJUSTMENT - JUNE 1961

	Frequency of Original Teacher Rating								
School Code	1	2	3	4	5	6	7	Total	Average
Second Grade									
1	9	18	24	25	19	13	7	115	3.82
2	6	11	13	9	7	8	5	59	3.75
3	9	17	18	12	18	14	7	95	3.88
4	6	12	18	22	14	12	6	90	3.96
5	11	18	20	13	17	12	10	101	3.82
6	4	8	7	11	5	6	4	45	3.87
7	4	4	6	12	10	8	8	52	4.23
8	11	14	26	32	17	13	8	121	3.83
9	9	16	21	24	21	14	9	114	3.96
10	8	11	10	20	11	10	6	76	3.91
11	6	10	14	11	15	9	5	70	3.94
All Schools								938	3.89
Fifth Grade									
1	7	13	20	27	18	13	8	106	4.00
2	6	13	19	27	16	12	6	99	3.95
3	9	17	20	24	16	15	6	107	3.84
4	11	18	26	37	27	17	7	143	3.91
5	4	8	11	17	10	7	5	62	4.00
6	4	6	6	8	7	4	2	37	3.76
7	4	12	18	26	14	10	5	89	3.94
8	4	9	12	18	12	9	4	68	4.00
9	7	12	12	18	15	11	6	81	3.96
10	4	8	11	6	12	8	4	53	4.02
11	4	8	11	15	12	7	3	60	3.93
All Schools								905	3.94

TABLE II

DISTRIBUTION OF TEACHER RATINGS OF PROJECT SAMPLE OF THOSE PUPILS NOMINATED AS HAVING NOTICEABLE LEARNING OR BEHAVIOR PROBLEMS PRIOR TO INITIATION OF PROJECT 1186

Group	Frequency of Teacher Rating of School Adjustment							Total Pupils Nominated	Total Project Sample
	1	2	3	4	5	6	7		
SECOND GRADE									
Boys	0	0	0	3	2	5	9	19	75
Girls	0	1*	1**	0	3	4	8	17	76
FIFTH GRADE									
Boys	0	0	0	4	4	14	6	28	98
Girls	0	0	0	2	1	4	2	9	56
ALL PUPILS NOMINATED	0	1	1	9	10	27	25	73	
ALL PUPILS IN PROJECT SAMPLE	17	36	47	58	59	60	28		305

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* Nominated as a pupil who has "a tendency to develop physical symptoms, such as speech problem, pains or fears associated with personal or school problems"

** Nominated as a pupil who has "inappropriate or immature types of behavior or feelings under normal circumstances"

Arbitrarily, twenty percent of the pupils in any grade was the original limit on the number of pupils who would be evaluated by the clinical teams. This means that five or six pupils from any teacher's class would be in the criterion sample. The project staff, in anticipating the attrition necessitated by parent's declining the opportunity to participate in the project, added additional names from the project list of the random population. The number of names added was determined by the school principal who anticipated the degree of cooperation from parents of pupils in the project list.

F. Securing Parent Participation in the Project

One cannot expect that the parent of every pupil sampled for the project will be interested in participating in the project. A rejection factor of ten percent is expected in research which requires door-to-door sampling. We would expect that in a research project which required parent participation to the extent of providing the social worker with a complete developmental history of the child as well as permission for psychiatric interviewing and psychological testing, one would have a much larger rejection figure than ten percent. A number of possible approaches to the parents were discussed with each school principal. On the basis of these discussions, the project staff left the decision as to type of parent contact up to the principal of the individual school. Regardless of the method used, the children falling at the top of the project list were to be contacted in the order listed, and if a rejection occurred, the next name on the list was to be used. The possible types of parent contact discussed with the school principal were as follows:

1. Principals contact each parent of project pupil by phone to schedule social worker home call.
2. Principals send letter home to parents to schedule home call.
3. Principals send letters home to parents of all second and fifth graders to inform them of the project and to let them know that their child might be picked at random to participate. School secretaries then call parents and schedule home visit.
4. Principals send letter home to parents of pupils on project list adding enough names from the project list to anticipate a given amount of rejection. Letters contain a tear-off sheet which the parent returns either with his child or by mail indicating that he is willing to participate. The tear-off indicates days and hours when parents will be home. Social worker, then, makes appointment directly with parents.

The first, second or third procedure listed above involves fewer chances of exceeding the number of pupils for whom individual evaluations were needed for the project. In any of these methods the principal would know exactly how many pupils he had contacted and be able to compare this with the numbers of individual evaluations he was scheduled to have from his school. None of the eleven schools used either method 1 or 2, two schools used method 3 and the remainder of the schools followed the fourth procedure. Both methods 1 and 2 require a good deal of the principal's and school secretary's time, so they were discarded. Method 3 requires less time from the principal or secretary, but more of their time than method 4. In the schools which used method 3, the secretary made the appointments for the social worker following the order indicated on the project list. Only a few of the parents refused to participate when called, but one parent refused further participation after the social worker made the home visit.

In method 4, it was necessary to anticipate that the tear-off sheets would not be returned by a number of parents either because they did not want to participate, because they forgot, or because it was too much extra trouble for them at that time. Tear-off slips were returned to school for about half of the pupils for whom they were originally sent home. Principals did not pursue a parent who neglected to respond to the letter. If they did not return the tear-off slips, no further contacts were made. Obviously, the research sample could be seriously biased by this procedure since the sample of pupils for whom the tear-offs were returned might be significantly different from those who failed to reply. A careful check was made of the teacher ratings of those who participated against those who did not participate. The distributions of teacher ratings can be found on Table III. Only one of these distributions was found to be significantly different - the one for second grade girls. A glance at the frequencies shows that the discrepancy comes largely from those frequencies in the middle of the distribution teacher ratings of school adjustment. This may be a result of sampling and not a result of other selective factors. The proportions of pupils at the ends of the distribution are comparable for this sample. The comparison of the frequency distributions for the total samples of participants vs non-participants shows no significant difference in the distributions. In spite of small differences in the proportions of pupils in each teacher rating category, the findings on Table III are taken as evidence that the sample which did not reply to the principal contact either in method 3 or 4 is not significantly different in terms of teacher rating of school adjustment from those who did not reply.

Social workers visited the homes of each of the pupils whose parents indicated an interest at this point in the project. In a few cases, it was not possible to contact some parents, even on second and third trials, even when calls were made directly at the home. In a few cases, children moved between the time their parents replied to the principal's contact and the time that the social worker could schedule an appointment. A few other problems were encountered also; however, it is important to note that of all the parents who indicated an interest in the project, only 6 parents refused consent for interviewing and testing following the social worker home visit. This is less than two percent of all those families contacted. A complete breakdown of the original number of pupils in the schools from which the sampling was made, the number in the original project sample and the number of participants and non-participants as well as other facts about the school contacts of the project group can be found in Table IV

G. Collecting Pupil Data on All Pupils Participating in the Project

During the time in which the school secretary or the social worker was contacting parents to schedule a home visit, research assistants were being scheduled to work in each school to collect information on all second and fifth graders from their school record files. Such data as they collected was needed on all pupils in the classes in which the project pupils were enrolled in order to obtain population data for all categories used to describe the criterion groups of well and poorly adjusted pupils. The cumulative record was used for this data-gathering process in addition to health cards and semester grade cards. As the research assistants collected the data, it was recorded in coded form directly on sheets which were to be processed later for key punching. Samples of these materials can be found in the Appendix (pages 12-14). When the information for each pupil was complete, the pupil data sheets were returned to the project office, alphabetized, numbered, coded according to school, coded according to original teacher rating of school adjustment and the presence or absence of a teacher, principal or nurse nomination of behavior problems. Master lists were then made of all second and fifth grade pupils in each school. Each pupil was assigned a code number which was used on all of his documents collected in the project during the screening process as well as for data on all the project pupils from the individual evaluation process.

Even though about half of the original project list was dropped at this point from the list for individual evaluations, the original teacher rating and nominations were preserved in the general code number for each pupil. Thus it is possible to use the original teacher rating as one type of criterion measure for the evaluation of the screening process.

TABLE III

Distribution of Frequency and Percentage of Teacher Ratings of School Adjustment by Grade and Sex on Sample Which Replied "Yes" to Research Invitation and Sample Which Did Not Participate

Reply to Research Invitation	Original Teacher Rating of School Adjustment														Total		Sig. level of Diff. in Distributions
	1		2		3		4		5		6		7				
	f	%	f	%	f	%	f	%	f	%	f	%	f	%	f	%	
SECOND GRADE																	
Boys																	
Reply "Yes"	7	9.3	9	12.0	10	13.3	9	12.0	13	17.4	18	24.0	9	12.0	75	100%	NS
Did not Participate	3	2.9	5	4.9	15	14.5	19	18.4	20	19.5	23	22.3	18	17.5	103	100%	
Girls																	
Reply "Yes"	4	5.3	8	10.5	22	29.0	8	10.5	15	19.7	12	15.8	7	9.2	76	100%	.05
Did not Participate	3	4.3	9	13.0	5	7.2	18	26.1	13	18.9	14	20.2	7	10.3	69	100%	
FIFTH GRADE																	
Boys																	
Reply "Yes"	4	4.1	10	10.2	11	11.2	22	22.4	21	21.4	23	23.5	7	7.2	98	100%	NS
Did not Participate	3	3.6	10	11.9	5	6.0	16	19.0	16	19.0	20	23.8	14	16.7	84	100%	
Girls																	
Reply "Yes"	2	3.9	9	16.1	4	7.1	19	34.0	10	17.9	7	12.5	5	8.8	56	100%	NS
Did not Participate	5	6.8	8	11.0	8	11.0	20	27.4	12	16.4	17	23.3	3	4.1	73	100%	
TOTAL SAMPLE																	
Reply "Yes"	17	5.6	36	11.8	47	15.4	58	19.0	59	19.3	60	19.7	28	9.2	305	100%	NS
Did not Participate	14	4.3	32	9.7	33	10.0	73	22.2	61	18.5	74	22.5	42	12.8	329	100%	

TABLE IV

RESULTS OF MAILING TO ORIGINAL PROJECT SAMPLE

	Second Grade					Fifth Grade				
			Results of Mailing					Results of Mailing		
School Code	School Population	Original Sample	No* Reply	Reply "Yes"	Reply "No"	School Population	Original Sample	No* Reply	Reply "Yes"	Reply "No"
1	115	60	45	15	0	106	40	32	8	0
2	59	12	7	5	0	99	14	7	6	1
3	95	28	13	15	0	107	37	11	26	0
4	90	40	26	14	0	143	36	14	22	0
5	101	38	17	20	1	62	30	13	15	2
6	45	26	12	14	0	37	18	8	10	0
7	52	32	16	16	0	89	40	17	23	0
8	121	30	12	18	0	68	26	11	15	0
9	114	25	5	20	0	81	32	16	16	0
10	76	24	6	17	1	53	25	13	12	0
11	70	9	3	6	0	60	12	3	8	1

Of all the letters mailed to parents, 321 returned the tear-off part of the letter indicating that the parents were willing to participate in the project. Social workers scheduled home visits with all of these families. 305 of the 321 parents agreed to participate in the project after the social worker made the home visit and gave the social worker the signed permission slip making it possible for the school to schedule the pupil for the psychiatric interview and psychological testing.

Of the 16 remaining pupils:

1 pupil was retained, therefore ineligible.

7 pupils dropped out or moved, reason unknown.

2 pupils did not keep social worker appointment, even on second and third try.

6 parents refused consent for interviewing and testing.

Original Teacher Rating

1	2	3	4	5	6	7
					1	
	1	1	3	1		1
					1	1
1					5	

Of the 305 parents who signed permission slips for testing and interviewing, 8 moved before the case study was completed. Case studies were completed for 297 pupils.

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* The project office was not informed of all the pupils who moved between June 1961 and November 1961 since letters were sent out from principals' offices. Some pupils in the "No Reply" column may, therefore, be pupils who have moved.

Chapter VI

ESTABLISHING THE CRITERION GROUPS

A. Background

In spite of the fact that most would agree to the statement that behavior is a function of personality, genetic and environmental factors, most of our efforts in studying effective and ineffective human behavior tend to deal with these factors as if they were independent of one another. Thus we find a number of research studies devoted to the relationship between suspected neurological impairments in children and acting-out behavior and learning difficulties. These studies attempt to describe organic factors as the sole determinants of the child's difficulties. On the other hand, it is not uncommon to find research studies on the problems of delinquent youth in which the primary effort is to identify social forces as the principal causal factors ignoring other possible contributors to children's behavior. Contrasted to these approaches is that of the clinician who is interested in studying the "self," often "treating" the self as a single determiner in the human behavior equation. The field of school mental health is exposed regularly to such etiological dichotomies. What is needed is no mind vs body or sociological vs psychological approach to studying and understanding behavior but a global concept that weaves together all of the predictors into a meaningful statement of their relationship.

Just as one should quarrel with those who attempt to describe children's behavior solely in neurological or "organogenic" terms, and with the social scientist who describes the delinquent in social or "sociogenic" terms, issue can be taken with the mental health specialist in describing behavior solely on the basis of "psychogenic" or "self" factors. While this may be an overstatement of the views of any of those in these fields, it is an important contrast to make in order to clearly describe the dilemma faced in predicting adjustment status of school children by attempts to discretely define aspects of the genetic, environmental or personality factors rather than to find a means of putting them together in predictive terms. In the field of abnormal psychology we are accustomed to such concepts as functional and organic mental illnesses. One inference from contemporary medical research is that such a dichotomy between etiologies of mental illness is no longer a useful concept. Research must continue to evaluate the interrelationship between these etiologies, weighing one more than another in a specific type of psychological problem. The importance of a particular independent variable will vary with the dependent variable; thus socio-economic factors may be very important in one functional relationship and relatively unimportant in another.

One can identify the types of independent variation which produce differences in human behavior and call these general types of variables genetic, environmental and personality. It is also possible to identify the types of independent variables which form the major focus of some of the studies in mental health. In other words, if we say that genetics, broadly defined, environment, as complex as it might be, and the infinite variations of self perception based on experience, comprise the principle independent variables in an equation of human behavior, we can also delineate certain areas of behavior in which the major effects of interaction of these independent variables are likely to occur. For example, mental health problems turn up in school or on the job; they are observable in family relationships; they may be the principal source of health difficulties; and they are also manifest in the variety of peer and group relationships. It is of interest, then, to use all of the identified independent variables to predict how a person will fare in school, how he will manage the problem of an employment situation, how he will get along with others, or whether he will be vulnerable to health difficulties.

To say that all of these factors are interrelated does not take us very far along the way to understanding how they interact to produce specific effects in a particular case. However, it is important to accept as a basic point of view that the human being does not function as a separate genetic, psychological, intellectual, or sociological being. All of the infinite variations in basic endowment, coupled with the olla podrida of the physical and social environment within which a person develops the self perceptions and awareness are the independent variables in the functional relationship between human behavior and its predictors.

As Miller has pointed out (71, p. 44), "The real problem is exactly how they (the predictors) achieve their effects. This problem remains largely unsolved. The next task which lies before us is to work out, step by step, the mechanisms by which each of the factors interacts with the others and makes its contribution. For example, we need to understand the mechanism by which a genetic factor interacts with the environment to produce a personality defect. What are the differences between a bright and a stupid person? How do children learn to discriminate fantasy and reality? How does sleep facilitate dreams? How do drugs produce hallucinations? How do neurological or hormonal changes produce their effects on personality? How do psychological stresses produce psychosomatic effects?"

As Miller further points out, "The organic foundation determines such things as the repertoire of innate responses which are available, the initial dominance of different responses, the innate strengths of various drives, the sensitivity to different stimuli and the ability to withstand various types of pain and stress."

This proposed concept of multicausality is summed up by the National Advisory Mental Health Council in 1955, "The concept of etiology as embraced by modern psychiatry differs from the simple cause and effect system of traditional medicine. It subscribes to a 'field theory' hypothesis in which the interactions and transactions of multiple factors eventuate in degrees of health or sickness."

Once having accepted the multi-causal, multi-factor point of view in regard to the etiology of mental health problems, the research worker must necessarily take the next step of identifying methodology which permits the development of workable research models for testing out the foregoing functional relationships.

The type of model may not be so important at this time as the effort to construct one. As Meehl (90) has pointed out, clinical psychology as well as the other clinical disciplines must begin to piece together the data from which they make certain diagnostic and predictive statements if they are to fulfill their commitment to the behavioral sciences.

The first objective in identifying more specifically the procedures needed to test out a multi-causality approach to the study of mental health is to locate and zero in on the target. It is much too broad a concept to talk about the prediction of human behavior. We must first delineate some of the possible dependent variables in the predictive equation. Some dependent variables have already been mentioned: psychosomatic disorders, learning difficulties, school adjustment, personality defects of a specified type, and so forth.

The particular research target and dependent variable which is the subject of this report is school adjustment. We are interested, primarily, in how children will fare in school, not just in the ability to do well on tests, or to manifest high intellectual potential, but how they will fare in the total relationship demanded in their educational situation. This means being able to relate to other pupils, being able to assign oneself to the task of getting homework completed, or finishing a classroom assignment, being able to succumb to and able to question authority in school, and finally being able to manage the daily challenge of an educational program which demands increasingly complex learnings and the acquisition of skills commensurate with the task. In an educational program, whether at kindergarten or graduate school, the challenge never lies behind. It always lies ahead. Our primary concern in this project is to predict how well second and fifth grade pupils are meeting and can meet the challenge of school in their immediate futures. Those who meet this challenge well are defined as well-adjusted; those who meet it poorly are considered to have poor school adjustment.

The general dependent variable of school adjustment is the validity criterion for this study. We can make this variable more specific by identifying the age and grade level of pupils about whom we will be talking. The subjects of this research project are school children, specifically of the primary and elementary grades -- most of whom are in the second and fifth grade. If one had better control over his research subjects than is usually available in the public school situation, it would be possible to study only pupils with certain measured school ability, or only those from specific socio-economic levels, or only those from areas with identifiable regional characteristics. Even without the possibility of holding some independent variables constant and varying the others, one can get a measure of each of these possible predictive factors and use multiple prediction models. At the least, a description of the pupils who are being studied can be made on the basis of a variety of genetic, environmental and personality variables.

B. The Criterion Problem

The first task of this project was to find the means by which a sample of school children could be measured on a scale of school adjustment status in order to establish the validity criterion described above. With a measure of school adjustment the screening process, the subject of this research, could be validated against this criterion.

Chapter V describes the procedures used in obtaining teacher ratings of school adjustment by first training the teachers in a definition of school adjustment as used in this project, and next asking them to rank all of the pupils in their classes in an approximate normal distribution. The assumption underlying the teacher ratings thus obtained is that good and poor school adjustments are not dichotomous categories, but ones which are on a continuum from children with fixed and recurring symptoms; to the vulnerable child who will have problems in school, but who can get along with help; to the pupils who have zest, enthusiasm, excellent coping powers, and who are able to manage most of their crisis situations with a resultant improvement in adjustment status. We know the child who has collapsed under the demands of the school setting; however, we have no comparable stereotype for the pupil who is at the other end of the extreme. It is possible that the distribution of school adjustment and the distribution of mental health are not normal curves, but ones with general form of $Y = aX^b$. Nevertheless, the operating frame of reference for this study for selecting the samples which were later to be judged by the clinical teams was that school adjustment is more analogous to mental abilities and normally distributed.

The rationale for using teachers to make this initial judgment of school adjustment from which a sample could be obtained for clinical evaluation is that classroom teachers are in the best position to observe school behavior of very large groups of pupils over a long period of time and in many different situations. As the number of years teachers have served in the profession increase, the number of pupils comprising their over-all sample of observed behavior increases also; therefore, the experienced teacher is probably the best source of behavior observations of school adjustment. This fact has been supported in previous research studies by Bower, (12) (16) Lambert (74), Werner (137), Eisenberg (34), and Fitzsimmons (38). These studies show that teachers are sensitive to a variety of behaviors of pupils and that they are able to select, independently of outside information, from their class rosters, those pupils who are the ones most likely to have difficulties which will be diagnosed subsequently by a mental health specialist, i.e., social worker, psychiatrist or psychologist. This faith in the ability of the classroom teacher to make a useful over-all judgment of school adjustment has been verified by large mental health surveys such as the one conducted by the Welfare Planning Council of Los Angeles County (135) where teachers were asked to estimate the number of pupils in their classes who needed immediate psychiatric assistance and the number who would need help in the future. Neubauer (98) and Fitzsimmons (38) also verified the predictive worth of teacher judgments of pupils. The value of teacher ratings of behavior has also been verified in research cited previously which uses teacher ratings to measure changes in pupil behavior or as validity criteria. We rely on teachers in the public school for noting those pupils who should be referred for a great number of different types of special services - speech help, eye and ear screening, evaluation for special education, remedial assistance, and referral to school guidance office for special study.

There is no doubt that teachers differ in their perception of a referral need because of differences in the teacher-perceived norms of what they consider to be typical or atypical of pupils of the grade level they teach. Previous work by Lambert (74) showed that teachers often "miss" identifying pupils with significant school problems when they are asked only to identify those whom they have referred or those who should be referred to school guidance offices. They appear to refer pupils whom they have difficulty teaching or pupils who are management problems. They do not refer a child with problems whom they feel they understand, even though they would be able to tell you in detail about his problems and his need for help if questioned about him. Lambert also found that the pupils whom teachers judge as being poorly adjusted, but whom they do not refer, have as high a delinquency rate and as poor an adjustment level in high school as those who had been referred.

The problem in using teachers as the principal observers of school adjustment comes when these selective factors in teachers' perception are not taken into consideration. If teachers are asked to evaluate the entire class, a task which they do not find particularly easy, they are able to distribute their pupils over a broad continuum of school adjustment. Table I demonstrates this fact quite clearly.

If teachers have their special biases of what is considered a referral problem, clinicians are no more free from biases in judging pathology or lack of pathology. The clinical process exemplified in the interdisciplinary team work of the social worker, psychologist and psychiatrist demands that diagnostic statements be made about children referred to them. Without the advantage held by the teacher in being exposed to large heterogenous samples of children of a narrow age range, the clinician sees pupils who come to his office for help. They are children whose parents bring them either of their own accord or as a result of a referral by some agent, a school, a family physician, or the court. When they make the appointment, they assume the responsibility for the first visit and they are willing to submit to the examination which follows. If treatment is recommended and followed, they are willing, in addition, to pay for the service and to undergo the necessary self-examination in order to be helped. Needless to say, such selective factors make the sample of children seen in child guidance clinics a highly special group.

Beside the selective factors at work in determining the group of children seen and studied in child guidance clinics, the task of the clinician becomes quite selective also. His job is first to describe behavior and determine a diagnosis using all the information which he can collect. His set in this undertaking is colored by the fact that he knows something is wrong with the child; if something were not wrong, the parents would never have come in the first place. His role is analogous to the dentist whose patient comes in with a toothache -- the source of the pain must be found and alleviated. It is a perfectly logical outcome of this role in the child guidance clinic, that the social worker, psychologist and psychiatrist become pathology oriented. In their diagnostic statements they list the suspected source of difficulty, describe strengths and weaknesses in the child's personal-social makeup and suggest procedures which are likely to assist the child and family in improving the child's adjustment. It is to be expected that these clinicians will look for problems and view all children as needing some type of assistance. Such an outcome of their work does not suggest that their observations are less accurate or that their descriptions are less apropos. Nor does this observation of the psychological set of the clinician suggest that he is less of a scientist in his approach to human behavior. The setting of his work and the demands of his immediate job role select out the occupational goals which he must attain.

The clinical team is considered to be the expert source of information about people. The extensive study of human behavior required for each of the disciplines represented in the team is acknowledged to make the clinician the best prepared professional person for making judgments about effective or ineffective behavior, effective or ineffective defense mechanisms, psychoses, neurosis, anxiety, and a multitude of other kinds of behavior.

The problem presented in school mental health research where a criterion group of pupils with good and poor school adjustment is required, is that there are bound to be discrepancies between a teacher-identified and a clinically-identified problem child. Differences will also turn up between those pupils whom the teachers feel have the least problems and those whom the clinicians feel have the least difficulties. Because of the different professional perceptions of each member of the clinical team, differences between them in selecting pupils with problems are bound to exist as well. A poor home situation will cause a social worker to hypothesize poor adjustment, a great deal of manifest anxiety will result in a psychiatric statement about personality problems and erratic and poor performance on ability and projective tests will be summarized by the psychologist into an hypothesis of poor adjustment and personality difficulties.

We could not, in selecting a criterion group, simply ask a clinician to come to school, interview a group of parents and children and ask them to make a list of the ones with problems, just as we would lose a great deal of information and bias our sample if we asked teachers only to make a list of those pupils whom they have referred or should be referred to the child guidance clinic for evaluation. Our sample would not contain all of the children with significant problems, and we would expect to find a considerable disagreement between the teacher and clinician-selected groups. A way had to be found in this project to utilize the training and skill of the clinician in evaluating a sample of pupils which would maximize his potential as a human observer.

The task was to begin with the sample stratified on the basis of teacher's over-all judgment of the school adjustment of every pupil in class. The distribution of teacher ratings of the sample selected by this means is described previously. The next step was to select clinical personnel and to develop procedures for the clinical evaluations of the project sample. These evaluations were to be made independently by each clinician without prior knowledge of the pupil's school status and without collaborating with one another.

C. The Selection of the Clinical Teams

Obtaining clinical personnel for a research study such as this requires careful consideration of the qualities which will insure optimum results. This job is somewhat simplified by the fact that clinicians are likely to select themselves. One finds that those who are interested in work such as this will be those who are willing to undergo professional self-scrutiny and who are willing to risk the security of their private offices and enter the province of the school. In addition, clinicians who are interested in this type of research have a basic belief in the value of early identification and prevention of mental health difficulties and they believe that the early school years is the place to begin. They must be willing to subject their regula working hypotheses to evaluation and they must acknowledge the fact that their work may be rejected either by the parents, the child or the school.

In spite of these obstacles, it was possible to obtain the services of well-trained and experienced psychiatrists, social workers and psychologists who were able to relate excellently well in the school setting, and who were willing to ask themselves over and over again throughout the project, "On what basis do I make the judgment that this child has a problem?"

D. Orientation of the clinical Teams

Before the clinicians were ready to meet with their first subject, meetings with them were scheduled to review the project goals and the working hypotheses of the project. The clinicians met as a group twice to discuss their particular roles in the project and to suggest how best they might be used in making the most reliable estimates of school adjustment. Following these two meetings each group of clinicians had several meetings within their own disciplines to discuss the particular interview procedures and the observations which they would make of every child. They collected related research on how other workers had carried on the same tasks, and reminded themselves frequently that making judgments on a sample of pupils without any information on referring problems, or school behavior, or developmental history would be very difficult. From the two large group meetings and the many individual sessions, each clinical group developed its own standard interview and testing procedure. Even though a variety of schedules devised by other workers were reviewed and discussed, the teams developed their own forms since a combination of a variety of other procedures seemed to best meet the needs of the project. In developing these standard procedures, the clinicians were asked to make their observations come within the traditionally defined roles of the members of the clinical team. We expected that a by-product of the project would be an analysis of the unique contributions made by the social work home interview, the psychological testing, and the psychiatric interview in evaluating a child's behavior. Even though some judgments could be made which would be common to all clinical groups, the majority of their evaluations were expected to be in a fairly narrow frame of professional orientation.

E. Important Variables to be Considered in the Assessment of School Adjustment Status

The objective given to the clinicians for their study of the sample of school children whose parents they were to see in their homes and whom they were to see personally was that they should develop a means for using the data collected during their interviews to come to some decision about the school adjustment status of the pupils. At the start, their goal was different from the one which usually governs their professional work. While their interactions with parents and children would enable them to make diagnostic hypotheses and to describe the pupil's present state of affairs, they had to go one step further in this planning phase of the project and determine how the data they could collect related to the research goal of determining the child's school adjustment. Furthermore, the clinicians could not rely on filling in questionable spaces in their interpretation of the child with data provided by another discipline; they had to work alone sharing only with colleagues from their own particular profession. All of these factors made their work difficult, but they were necessary prerequisites to establishing a criterion group of pupils where an analysis could be made later of the characteristics of the well- and poorly-adjusted pupils on the basis of uncontaminated observations.

The first step in developing the standard interview schedules and testing procedures was to review types of data which could be gathered in this project which had previously been shown to be predictive of mental health status, health status or school adjustment status of school children. Since school variables would be used in other parts of the project as predictors, the clinicians had to focus entirely on those bits of information which they could collect without relying on information from teachers, principals or nurses or from school cumulative records.

The first step was to review research which indicated the predictive value of any data which could be inferred to be measures of specific independent variables categorized generally under the labels of genetics, environment or personality. The following review of such research contains samples of what has been done in this area, but is not necessarily inclusive of all work which has been completed.

1. Predictive Variables Categorized as Genetic Factors

a. Pre-Natal Factors

The presence of genetic conditions is very much related to socio-economic variables as has been shown by Masland (86). Nevertheless, Masland indicates that the presence of certain pre-natal conditions, even though they may be directly the result of socio-economic factors, is predictive of neuropsychiatric difficulties during the child's developmental period. The mother's health during pregnancy, her nutrition, the mother's age at the time the child was conceived, endocrine disorders, toxemias, radiation and medication are all factors which have been shown to play a part in the healthy development of the child. The Kent Pediatric Study (60) verified the predictive validity of some of these data in their study of the incidence of health in 10 and 11 year old children. They identified the mother's employment before the child's birth, the presence or absence of birth control procedures, the pre-natal care of the mother, and the incidence of physical conditions in the family history which are known to be hereditary, as present significantly more often in their sample of "unhealthy" children.

b. Birth Conditions

Birth weight of the child was shown to be predictive of poor health (122) and can be related to premature birth, another fact worthy of note in gathering predictive data about degree of the child's vulnerability to problems. Birth trauma resulting in manifest or suspect brain injury has also been shown to be a major cause of later behavior problems; however, the effect of the brain injury is dependent upon the child's psychological defense patterns and upon the environmental forces acting upon him. The growth pattern of the child, early illnesses, health problems, and congenital or acquired physical defects are also found in significantly greater proportions in the records of children whose potential for healthy emotional development is at risk. (101).

c. Physical Conditions

Allergies, ulcers, skin disorders other psychosomatic disorders are commonly thought to be related to a constitution pre-disposition and a psychological environment which precipitates the disorder as further studied by Wenar (136). There is sufficient evidence from previous research to indicate that a potential relationship exists between physical health and mental health. The inclusion of data which describe genetic factors in the family's and child's history which might be found to be predictive of poor school adjustment as defined in this project is imperative.

2. Predictive Variables Categorized as Environmental Factors

a. Housing Environment

Numerous studies during the past several years have indicated a predictive relationship between housing environment and evidence of health status including indices of mental health status. While it is not known whether it is the housing environment per se which is the contributing factor or whether it is a low level of education, low income, or any number of other factors, the fact remains that there is an inverse relationship between the incidence of problems of a mental health nature and the quality of housing. Wilner (137) reviews some of the research which relates housing environment to mental health and concludes that even though the nature of the relationship is not as yet clear, housing environment is clearly an important epidemiological variable in mental health status. Spence's study (125) of the incidence of health in a small English community also demonstrates that there is a relationship between physical health and emotional robustness and the type of dwelling in which the families live, the density of the household, and the economic resources of the neighborhood.

b. Socio-economic Status

Socio-economic status is commonly measured by some combination of ratings of residence, occupation, education and source of income. The housing environment which was treated above, separately, as a predictor of mental health status, is often contained in indices of class status, which use a weighted sum of ratings on each of these socio-economic variables. Class status has been shown to be clearly related to whether an individual is or is not a psychiatric patient. Hollingshead's study (54) of the relationship between social class status and mental illness demonstrated that: 1) a definite association exists between class position and being a psychiatric patient, 2) the lower the social class, the greater the proportion of patients in the population, 3) the greatest difference occurs between the two lowest indices of class status - the group with the lowest social class ranking has the greatest incidence of mental illness. Not only is social class status a factor in the incidence of mental illness, but Hollingshead shows that it is also a factor in the types of illness patients present to psychiatrists.

The impact of socio-economic status of families on their offspring is described by the findings from the Midtown Manhattan study (126). Srole's observation supported by data is that the offspring of low socio-economic families at all adult age levels reflect "maximum vulnerability to mental morbidity and minimum fulfillment of wellness." He postulates that "1) handicaps in personality resources, social skills, and cohesion of parents, 2) the complex of effects directly generated by poverty, and 3) the community's stigmatize-rejection process, mutually reinforcing each other" may go far toward explaining this general vulnerability to mental health difficulties.

Most of the research relating mental health to socio-economic variables has used correlations between socio-economic status and rates of treated illness, or prevalence rates. All of the workers who conducted these studies are aware of the fact that socio-economic status is a complicated predictor variable. A great deal of further study is necessary before the complexity of single variable predictors which make up the general variable of socio-economic status can be defined and tested for their significance in predicting types of health or mental health problems. Socio-economic status is important to mental health as Leighton (80) points out, "not merely or even primarily because of the purchasing power that is represented; socio-economic status influences sentiments, values, time-perspectives, roles, child-rearing practices, the imposition of social controls, and, in general, life styles. Some of these dimensions are undoubtedly linked much more closely with mental health than are others."

Nevertheless, socio-economic status, complex as it may be, is importantly related to the incidence of mental health problems. It is also related to school difficulties as perceived by teachers (3), school drop-outs (73), a child's choice of friends (99), measured intelligence (3), and school achievement (48).

c. The Family Environment

"The essentials of a stable and happy home are a sound dwelling of sufficient size, a reasonable income wisely used, and parents who enjoy a satisfying relationship with each other and are sensitive to their children's needs." (94). The relationship of an adequate family environment as thus defined by Spence is further amplified by the fact that most serious physical illness is coming under control, that primary poverty has almost gone, and that standards of hygiene, nutrition, and education have greatly improved. The evaluation of a healthy family environment is usually focused on the mother-child relationship. Sears (117), Merrill (92), Schaefer (113), Glidewell (45), Serot (119) and several others have worked toward developing instruments which could be used to evaluate mother-child relationships. Merrill observed mothers and children of pre-school age in a play situation and classified the behavior according to an objective instrument which contained items measuring the degree of contact, the degree of specificity of control, and the degree and manner of facilitation and inhibition imposed on the child by the mother. Sears used three types of measurement to secure scores on various aspects of dependency and aggression in children; teacher rating, direct behavior observation and dollplay. He then related these behaviors to behavior of the mother and her reports of the child's early history during an interview setting Schaefer organized a number of observations of maternal behavior into a set of quantifiable scales. First a construct was described and then observable traits were matched to the construct. Next the interviewer classified his observations according to the categories on the scales. A number of interviews were taken over a period of years and the data from the scales were then related to facts in the child's developmental history.

At least one factor analytic study of such data that has been collected on parent interview schedules was conducted by Lorr (84). He found that three statements provide an economical condensation of the principle variables in the interview data. They were summarized as follows: "1) How far does this home situation sustain and encourage dependence and how far does it deny satisfaction to dependency? 2) How far do the methods of child training reflect democratic practices or values, or to what extent are they authoritarian and undemocratic? 3) To what extent is there strict orderliness in the home, or to what extent is the home life unorganized?" Stone (127) formulated the variables in a healthy mother-child relationship after eighteen months of clinical experience. While his formulations are still under review, he recognized four main maternal attributes which seem to generally sum up the areas of investigation in the realm of the relationship between a mother and her children:

"A. Motherly love or affection, involving:

1. An intense feeling of relationship to the child and unqualified acceptance of him.

2. Sensitivity to the child's needs, both recognizing these and responding to them.

B. Helping the child in development of independence, which involves:

1. The ability to see the child as a separate person.

2. A free emotional interplay with the child.

C. Protection and support

An awareness of present and potential dangers in child's environment and of her child's weaknesses. Here is included also the channelizing of development to socially accepted goals.

D. Controls

A mother must impose limits, and an educational function is involved here."

In a majority of the research on the mother-child relationship, the research goals are primarily finding a means of relating, objectively, maternal behavior to specific life experiences of the child. While the criteria for child behavior vary with the research study, there is evidence to indicate that with inadequate mothering as described by failure to meet any of the above criteria one will find a higher incidence of school problems as measured by teacher ratings - Sears (116), a greater number of symptoms of emotional difficulties - Glidewell (45), more susceptibility to health problems - Wenar (136), Spence (125), and Kent (60), and a poor perception of personal adjustment on the part of the child - Serot (119).

d. Other Environmental Factors

Nationality of the family becomes an important variable in mental health status when the family has recently moved into a community. Rural vs urban living may also be an important variable though it is difficult to say whether a greater incidence of mental health problems turn up in a city because there are facilities or whether the greater incidence is related to factors in urban living. Leacock (76) describes fully the research in these areas and suggests the limitations which should be placed on inferences made from the comparisons. While little definitive data are available on religious participation of the family, this fact as well as other information on the involvement of the family in activities outside the home may be worthy of further study, Spence (125).

3. Personality or Self Factors Predictive of School Adjustment

The interaction of genetic and environmental factors provide the raw materials for the development of individual differences. Personality development like physical development follows a regular sequence of events as shown in the study of many thousand infants and children conducted by Gesell and Amatruda (42). Witmer and Kotinsky (138) stress eight stages of development based on the concepts of Eric Erickson which are necessary to the achievement of a healthy, mature personality. The first five stages are of interest to this report since they cover the age range of the children who were evaluated in the criterion sample. These five stages are reproduced here from Chapter 1 in Witmer's and Kotinsky's test, The Making of a Healthy Personality.

Age Period	Characteristic to be Achieved	Major Hazard to Achievement
Birth to 1 year	Sense of trust or security - derived from affection and gratification of needs.	Neglect, abuse or deprivation of consistent and appropriate love in infancy; harsh or early weaning.
1 to 4 years	Sense of autonomy - child viewing himself as an individual in his own right, apart from parents, although dependent upon them.	Conditions which interfere with the child's achieving a feeling of adequacy or his learning of skills such as walking.
4 to 5 years	Sense of initiative - period of vigorous reality testing, imagination, and imitation of adult behavior.	Overly strict discipline, internationalization of rigid ethical attitudes which interfere with the child's spontaneity and reality testing.
6 to 11 years	Sense of duty and accomplishment - laying aside of fantasy and play and undertaking real tasks, developing academic and social competencies.	Excessive competition, personal limitations or other conditions which lead to experiences of failure, resulting in feelings of inferiority and poor work habits.
12 to 15 years	Sense of identity - clarification in adolescence of who one is and what one's role is.	Failure of society to provide clearly defined roles and standards; formation of cliques which provide clear but not always desirable roles and standards.

Coleman postulates (30) that superimposed on these developmental tasks are three basic hurdles to be got over in order to meet each stage successfully. These hurdles are the ability to move from the dependent relationships of infancy to the independency of adulthood. Second is the problem of substituting for the drive for pleasure as described by Freud's Pleasure Principle, the necessity of facing and dealing with reality in order to meet one's needs. Being able to become reality-based means that it is necessary to achieve an accurate frame of reference and to learn to delay need gratification in the interests of long range goals. Third, the entire developmental period is directed toward the mastery of intellectual, emotional, social, and other competencies or adjustive skills essential for adulthood. From infancy to adolescence to adulthood, the individual moves from incompetency to competency in the acquisition of information about himself and the world which is prerequisite to evaluating and coping effectively with education, employment, interpersonal relationships, marital problems, and parenthood.

It is necessary in presenting a point of view regarding personality factors and their relationship to school adjustment to add to the concept of developmental tasks which must be faced and met by every person, and the concept of some additional hurdles to be passed in order to promote personality development, some notion of the structural aspects of personality which the individual develops and which in turn become his armamentarium for dealing with life situations. Caplan (26) lists 1) cognition, the seeing, hearing, knowing part of the personality 2) selection and integration, giving meaning to experience, integrating it with other experiences and finally storing it for future use 3) planning, the capacity for problem solving 4) control, controlling motility and impulses 5) synthesis, the equilibrium-producing aspect of the personality which organizes all experience into a consistent, identifiable aspect of an individual which is perceived by the person himself and by others as his particular individuality and finally 6) object relations, or relationships with people and things.

Personality factors are related to adjustment in the sense that imperfect development will leave a child with a degree of handicap with which he must deal in some way, effectively or ineffectively. If he is bright and has good family relationships, he can manage much more successfully a temporary upset with his friends; however, if his family relationships are poor and if he is not so bright, the temporary upset with his friends may in time become quite permanent since he does not have other strength-giving forces which will enable him to make the adaptations necessary to deal with such situations. Personality does function in a given situation as a unitary whole. What goes on in one part of the personality affects what happens in other areas. Development, personality structure and motivation are forever hooked together in an adaptive unit.

Most of the research on personality has been directed toward description of individual differences, not on the relationship between personality data and other criteria. Normative data are provided on intellectual development by intelligence tests, personality factors by population norms on personality tests, growth schedules, health, behavior in a variety of situations, but the scales are not necessarily on a continuum which covers a range from good to poor mental health; therefore, these data may be good descriptively, but poor predictively. The predictive value of personality data has been continually criticized, but more interest in this type of research has been generated during the past few years and the results are not unpromising. While it is difficult to find an abundance of studies which predict mental health or school adjustment status from personality data, a few studies can be mentioned as examples of some encouraging areas of investigation.

Glidewell (45) and Peller (103) found that the number of symptoms observed in the child by the mother was directly related to school adjustment status. In the Kent Pediatric Study (60) a constellation of cooperation, level of maturity, imagination, reality sense, social sense, and balance as inferred and rated from Rorschach records lead to differences between children identified as "healthy" and those with poor health. Harrower (53) postulates that psychological test data can be used to arrive at ratings on a good to poor mental health scale of productivity, relation to reality, thought content, constructive fantasy, emotional tone and social attitude, and that such ratings will be predictive of other criterion data. Serot (119) found that whether or not a child perceives his home situation as good or bad was related to his school adjustment. Gronlund (50) found social acceptability in the neighborhood to be related to acceptability in school, and social acceptability by peers in school was found to be related to failure to finish high school by Kuhlen (73). Goodlad (47) and Sontag (124) give evidence for a positive relationship between personality and achievement, while Buswell (24) shows a relationship between the social structure of the classroom and achievement. Kagan (58) noted that there was a significant relationship between the need for achievement, competitive strivings and curiosity about nature and the change in Binet IQ scores in a sample of children who were tested every six months from six to ten years. Bower (12) (17) has demonstrated that children with emotional difficulties have poorer school achievement on the whole than their classmates and also that their ability as measured by group intelligence tests is lower. Lambert (75) found that clinical psychologists' blind ratings on the WISC, Rorschach, and Bender on a one-to-five scale from good to poor school adjustment were significantly different when ratings for two groups of children, one judged to be well-adjusted and the other judged to be poorly-adjusted in school, were compared. Meyer (93) compared Rorschach scoring categories with reading achievement in the primary grades and found that location, use of color and card rejections were different for average, better than average and below average reading groups. He found also that there was a significant relationship between intelligence and these same categories. Robbertse (108) discovered that a sample of 100 pre-delinquent pupils, when compared with an equal number of controls, was significantly different in terms of number of Rorschach cards rejected and reaction time.

In Gough's study (48) of the relationship of socio-economic status to personality inventory and achievement test scores, the correlations between personality inventory scores and achievement tests were negative from a value of -.22 to -.28. When intelligence was partialled out of the measures, these correlations were reduced significantly. Another finding indicative of some of the questionable results obtained in attempts to predict personality factors was demonstrated in Sarason's study of the Rorschach behavior of high and low anxious children (111). He found that psychologists' blind ratings of the Rorschach protocols of the high anxious and low anxious groups could predict anxiety level only a little better than chance and suggests that the psychologists interpreted guarded behavior in the test situation as indicative of anxiety when these same subjects had low anxiety scores. Obviously some outside criterion of mental health status, or school adjustment is needed in order to fairly evaluate the predictive value of personality data. It is in this domain where clinicians have the opportunity for making an important contribution, but more emphasis on uncovering the predictive aspects of their work and verifying such hypotheses with carefully conducted research studies is necessary. There is no doubt that the usual descriptive data collected about people is helpful in understanding them; we do need, however, to know more about "how much is too much" of any one aspect of the complex of personality variables.

F. The Development of standard interview and testing procedures

The job of the clinicians in gathering data on the project sample from which to infer a criterion measure of school adjustment status was first of all to remain within the clinical roles assigned to them by tradition and training. The psychiatrist was assigned the job of making a psychiatric evaluation from evidence gathered from an interview with the child; the psychologist's role was to make judgments from test data and behavior during testing; and the social worker's task was to gather case data and make inferences about the familial situation from an interview with the mother at the home of the child. The project staff recognized that such limitations on functioning placed some limitations on the workers since they had to rely entirely on clinical materials which could be gathered in these restrictive settings. The disadvantage of the setting was felt to be offset, however, by the fact that the data gathered would be that which could be gathered by others in these disciplines since these roles are well-accepted in the clinical professions, and that it would be possible to determine just how the clinicians functioned in gathering information from which to make predictions about school adjustment status.

Some additional comments about how the psychiatrist, psychologist and social worker view their professional roles in clinical appraisal will serve to clarify the activities of these workers in making the appraisals for the criterion measures. The psychiatrist utilizes a very small fraction of a transaction between two people. The statements which he presents to the child represent stimuli that are imposed on the child and the child's responses are evaluated in comparison to the responses of other children in similar situations. These responses are expressed in behavior, sometimes motor, sometimes verbal and sometimes indirectly verbal as in the nature of a dream verbally communicated. The psychiatrist must make certain conclusions about the relationship between the stimuli he provides and the responses of the child. Contrary to psychological testing replication of the interview situation cannot be achieved because the same subject will respond differently on another occasion or with another psychiatrist. Nevertheless if these procedures were applied often to large groups of similar subjects, enough data could be derived to make possible some experimental or statistical manipulations which could bring meaning to the transaction between the psychiatrist and the child, or to make judgments about the probability of certain behavior occurring during certain situations. For the purpose of observing children under these specified conditions even though the child may behave differently in this setting than under other environmental conditions, the psychiatric interview offers an experimental situation which has the potential of predictive data from children's behavior.

The goal of traditional psychiatric diagnosis (33) is to understand the history of the presenting complaint and its etiology, and to develop a plan of treatment designed to eliminate, control or ameliorate the negative forces, while making the fullest possible use of the positive forces in the child and his situation. Typical psychiatric evaluation includes the collection, integration and evaluation of pertinent data, the identification of etiological factors, specific or multiple and the formulation of a working diagnosis, prognosis and treatment plan. The first approach to the child psychiatrist is usually made by the parents or by a referring source, such as the school, on behalf of the parents. Diagnosis in child psychiatry is directed at an understanding of past and present interactions and at the strengths and weaknesses of the major persons in the child's constellation - the child, the parents or parent substitutes, siblings, other key relatives, and the personnel of schools and other social institutions who may influence his maturing personality. Clearly delineated and universally accepted diagnostic classifications for children have not been established. The child psychiatrist sees an immature individual who is in a fluid state of incomplete personality development, characterized by normally rapid physical and psychological changes.

This somewhat lengthy description of the child psychiatrist's usual method of functioning is necessary since in this project, his role was more markedly different from his usual role than the other workers. In this study the psychiatrist had the child as his only source of information. No case history data from the social worker were made available to him, no information from personnel in the schools, and no psychological test data. His job was to spend time with the child determining beforehand in conjunction with his colleagues what types of stimulus questions and procedures would be used and what observations would be made on a standard interview schedule. The limitations of the setting also had to be observed. Since the children who were to be evaluated represented a broad continuum of behavior and permission had been given by the parents for an evaluation of the child's attitudes toward school and education, the psychiatrist could not exceed the limitations of this sanction.

The clinical psychologist's role in this project, unlike the psychiatrist was more typical of his usual manner of functioning. The psychologist uses standard tools of measurement for which he has established norms. In a battery of tests selected for administration, he will include tests of cognition and perception and attempt to get some measure of the affective behavior of the child from a variety of projective devices. For each of these tests some standard method of transferring a response into an objective scoring scheme is available and there are, for the most part, standardizations of these scoring categories so some inferences about differences from population parameters can be made about a particular child's performance or about the performance of a group of children. Utilizing standard testing conditions the psychologist observes the child's response to the situation and records significant behavior. He also notes how the child responds to test materials, and takes special care to record an affective response which would later provide a clue to an area of particular difficulty for the child, and finally prepares a report of his observations, test scores, and predictions about how a child differs from the norm.

Even though the psychologist has the benefit of standard scales with which to interpret a child's test scores, he has some of the same problems as the psychiatrist since information about a referring problem or case data from the family-child relationships are extremely useful in making sense out of particular test behavior. In addition, in situations where the psychologist is called upon to make predictions about the degree of severity of a school adjustment problem from the data he collects, few validity data are available which make possible a statement about the importance of a particular finding in predicting a behavior syndrome.

Social workers are interested in helping clients find relief from environmental and/or emotional pressures. Selby (118) further goes on to comment on the fact that the field of social work needs to describe more fully how the social worker helps clients to make use of their own adaptive capacities in resolution of their problems and utilize their own strengths and resources for problem solving.

Social case work training provides a good background for understanding child development and making a clinical appraisal of the individual. In both academic and field work experience, however, the emphasis in training is frequently greater in the understanding of deviant behavior, just as in the case of the psychiatrist and psychologists, than in the understanding of characteristic patterns of child development at different age levels. Even though Vide (131) makes note of the fact that knowledge of child development at different age levels is very important for the school social worker, the focus of social work is on description of behavior, and the child or family becomes the norm.

Some work toward developing typologies for caseworkers has been accomplished by Selby. She reviews the needs for typologies, the resistances to developing them, but sums up the problem by challenging the profession of social work to come to some agreement about what they need to know in order to insure limits, relevance and direction for their helping efforts.

The focus of the social worker is, therefore, on evaluating the state of mental health of the child in his environment. His basic equipment is an awareness of the cultural and social components in the organization and control of human behavior. He becomes sensitized to the social milieu by systematic training and experiences in different cultural environments which make him aware of motivations from a cultural point of view. This aspect of his training is analogous to the sensitizing of the psychoanalyst to unconscious motivations through a training analysis. Hollingshead in (54) states that the evaluation of an individual situation is based on at least three basic operating assumptions:

1. Social behavior is learned by individuals through their interaction or association with other members of their society.

2. The content of what individuals learn is provided by their society's culture.

3. What individuals learn is determined by participation in society's culture.

These workers who comprise the clinical team represent a combination of years of training and experience in observing, describing, classifying and prognosticating human behavior. Each has his own radar by which to direct the course of his observations. Sarbin (112) provides a philosophical point of view in understanding the clinical process. He states that "no single process or event can be isolated as the important locus for the study of inference as an aspect of the clinical process. We can recognize five outstanding features:

1. The observer is engaged in the transformation of knowledge. He brings into the enterprise various kinds of dispositions, skills, beliefs, attitudes, assumptions and so forth, which limit the nature, direction and scope of the inferential product.

2. The direction, purpose, aim, or objective of the cognitive work of the clinician must be taken into consideration.

3. The input of raw material out of which inferences are made must be defined. They are aspects and properties of the objects of judgment.

4. The modus operandi of the inferring person accounts for the implicit and explicit manipulation and transmutation of raw sensory events into knowledge about people.

5. The product of the inferential enterprise, the outcome of the process, is a diagnostic statement, a classification, a thumbnail description a prediction and so forth."

It was thus important to recognize and account for the particular skills and background of each of the professions constituting the clinical teams who were selected to evaluate a criterion group of second and fifth grade pupils. The interview schedules which they used in gathering data about children had to present realistically a task which they could accomplish with their particular modus operandi. This project required that the input of data from which inferences and ratings were later made was to be recorded; therefore scrutiny of predictive research as described previously had to be made before the schedules could be developed. In addition, standard procedures had to be followed so that reasonable assurance could be had that procedure used in this project was similar for all pupils and would have applicability for other workers. The inferential product of the individual evaluations was a number of qualitative ratings of pupils or families based as much as possible on the objective data which were recorded on the interview schedules.

1. The Psychiatric Interview Schedule

Ernest Kris (70) was one of the first psychoanalysts to emphasize the importance of predicting from observational data that pathology exists in a given child. He was primarily concerned with recognizing symptomatology before it became manifest, and to spot danger to the child before it appears. Anna Freud (41) in reviewing Kris's work cites the difficulty in clinical foresight. She points out that: 1) there is no guarantee that the rate of the maturational process on the positive side of ego development and drive development will be constant; 2) there is no way to approach quantitative factors in drive development, nor to foresee it; and 3) the environmental factors in a child's life will always remain unpredictable since they are not governed by any known laws. Nevertheless she feels that there is a place for prediction in child psychiatry in: 1) observing anxiety and symptoms even though it is difficult to draw the line between prediction of pathology based on authentic danger signals, and a diffuse and indiscriminate overanxiousness; 2) gathering information about the early mother-child relationship; 3) noting the presence of powerful interests, curiosity, fixation, sublimations and so forth; 4) making some assessment of traumatic events. However, Anna Freud makes a special point of the fact that it is difficult to know which aspect or element of a given experience will be selected by the child for reaction and emotional involvement.

The psychiatrists who participated in this project were well aware of such admonitions against making predictions about behavior from a single observation. Nevertheless, they were willing to develop procedures which they felt could be used to assess a number of children in a school setting. A beginning was made by making large lists of behaviors on a continuum from what could be inferred as indicative of poor adjustment to what could be inferred as indicative of good adjustment. Next a list of symptoms was developed which could be expected in a sample of seven and ten-year-olds with possible school difficulties. Observations of the child, such as his posture, size, physical appearance, health, speech, indicated interest in school and others were reviewed by checking forms used in clinics for making such child observations. Finally a number of useful observations which could be recorded easily in a few minutes after the child was interviewed were selected and placed on an interview schedule.

In addition to observational data, the psychiatrists had to decide on the qualitative judgments which they would make about the child. These had to be based on material which could be gathered in the time spent with the child in school, as well as on aspects of personality or genetic variables which could be inferred from the child's behavior during the interview period. The qualitative judgments had to be kept to a minimum since each child had to be rated with respect to every other one the psychiatrist saw. A point of diminishing perception of differences between children is soon reached when a number of qualitative judgments are required. After much negotiating and professional soul-searching, the psychiatrists suggested the following qualitative judgments and these were then included as the summary inferential ratings which they would make from their experience with the child:

1. Is this child a child who has serious learning difficulties?
2. Is this child one with serious behavior problems?
3. Does this child need psychiatric treatment?
4. To what extent can this child's behavior be modified.
5. Is this child comfortable with himself?
6. Is this child comfortable with others?
7. Does this child have appropriate contact with and relationship to reality?

Finally the psychiatrists decided that a brief summary of their impressions of the child would allow for the inclusion of any significant observations which did not find a place on the interview schedule or in the qualitative judgments. The complete interview schedule can be found in the Appendix.

2. The Psychologists Testing Schedule

Measures of intelligence, perception and affective behavior were selected by the psychologists as the minimum battery of tests which would yield the maximum amount of information in the suggested one-hour limit of testing time for each child. Psychologists have a great number of measurement tools from which to select; the problem is selecting those which will provide the best opportunity for observing the responses of the child as well as selecting those with the greatest amount of previous research.

For a measure of intellectual status and its relationship to personality style the Wechsler Intelligence Scale for Children was selected since it provides a good sample of mental tasks. The entire WISC battery of 12 sub-tests was considered too lengthy if other tests were to be included in the one-hour testing time. A short form of the WISC was used which included those sub-tests which 1) gave most personally meaningful material, 2) correlated well with the Full Scale IQ, 3) required a minimum amount of time to administer, and 4) were convenient and easy to use. In addition, no less than two sub-tests on each scale, Verbal and Performance, were to be included. The rank order of correlations with the Full Scale IQ as listed in the Manual is as follows:

Age 7½	
Vocabulary	.71
*Information	.69
Picture Arrangement	.68
Arithmetic	.66
*Comprehension	.64
*Similarities	.64
Object Assembly	.64
*Block Design	.63
*Picture Completion	.56
Coding	.50

Age 10½	
Vocabulary	.87
*Information	.82
*Comprehension	.76
Arithmetic	.76
*Similarities	.72
*Block Design	.72
Picture Arrangement	.70
*Picture Completion	.61
Object Assembly	.58
Coding	.54

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*Sub-tests marked(*) are those included in the Short Form of the WISC administered by the project sample.

Littell (82) reviewed all of the research on the WISC for a period of ten years and concluded that there were few, if any, adequate investigations of the predictive validity of the WISC. He commented on the value of the WISC as an instrument for making hypotheses about personality styles from test responses by noting that nowhere in the literature covered was there more than the barest beginning of the investigation of the validity of various interpretive hypotheses. He made further note of the fact that since most inferences are based on an intuitive appraisal of the content of the sub-test and the informal observations of test administrators, there is a need to study variables in the relationship between examiner and examinee, to evaluate the circumstances of the examination and the effect of repeated administrations.

Glasser and Zimmerman (44) have attempted to quantify some of the observational data which can be obtained from the WISC and they list a number of behaviors which are frequently noted in response to test items as well as some suggestions for their interpretation.

The Bender Visual Motor Gestalt Test (11), a test of perception, requires the child to reproduce designs appearing on nine separate cards. These nine designs were selected from Werthheimer's original 21 designed to investigate gestalt theory. It has been used to assess the development of perception in children, to note the effects of brain injury, and in gathering data to be used in studying neuroses and psychoses.

The most useful predictive research on the Bender has been done by Byrd (25) Clawson (28) and Koppitz (65), (68), (69). These workers have shown that rotations of designs, distortions, problems with angulation and closure and arrangement of materials on the page are patterns of response which have potential for significantly predicting those pupils who will have difficulty in school and reading achievement. The administration time is minimal. The Bender was used by 80 per cent of clinicians surveyed by Schulberg (114). These clinicians indicated that it had "some or great" diagnostic value.

One of the most common projective tests used in clinical diagnosis is the Rorschach. Ames (1) (2), Beck (7), (8), (9) Ford (39) Halpern (51) Klopfer (62) (63), Ledwith (77) (78), and Rabin (106) provide materials on the use of the Rorschach with children, scoring procedures and normative data. Space cannot be provided here to summarize the materials from all of these documents. In summary, the Rorschach appears to have considerable value as an instrument for drawing inferences about personality, reactions to environmental settings, affect, and content of cognitive experiences in a highly emotional setting. While the above work is concerned primarily with scoring procedures and the use of the Rorschach record in making a diagnostic summary about children, little other research has been done with the predictive validity of certain Rorschach signs. The normative data provided by Ledwith and Ford offer at least one departure toward prediction from Rorschach responses, but we can determine from their work only the probability of a particular finding. Siegal (121) found a relationship between certain Rorschach signs and positive or negative response to psychotherapy, and Robbertse (108) and Meyer (93), as mentioned previously, found certain responses more frequently in children with delinquent or reading problems respectively.

The battery of tests finally selected by the psychologists was the short form of the WISC, the Bender and the Rorschach. In addition the categories for observation of the child's reaction to the test materials and the child's reaction to the examiner as developed by Glasser and Zimmerman (44) were included in the testing schedule on which all scores and all observations were recorded.

The psychologist like the psychiatrist and social worker was responsible for making inferences from the "hard" test data to more "soft" statements about the child's adjustment status. They selected the following qualitative judgments as being those which could be made on the basis of their information which would provide for measures of independent variation in school adjustment status. The qualitative judgments which they chose were:

1. Does this child have poor intellectual functioning?
2. Does this child have severe perceptual difficulties?
3. Does this child have severe personality disturbances?
4. Does this child have problems relating to his classroom teacher?
5. Does this child meet learning tasks effectively?
6. Does this child have creative potential?
7. Does this child have poor school adjustment?
8. Does this child have poor school achievement?
9. What is the over-all rating of the WISC?
10. What is the over-all rating of the Bender?
11. What is the over-all rating of the Rorschach?

The complete testing schedule and list of qualitative judgments which were used by the psychologists for all children whom they saw can be found in the Appendix.

3. The Social Worker's Home Interview Schedule

Most of the data about genetic and environmental factors which could be predictive of school adjustment are collected by the social worker in the routine gathering of developmental history information. In this project social workers made a home visit which enabled them to gather a number of important facts about the neighborhood in which the family lived, the condition of the home and other important environmental variables. The difficulty in developing the interview schedule for the social workers came about in reducing the schedule to a sequence of data which could be gathered in one hour's time. In addition, the social workers knew that in the simple reporting of facts about the child's life, little opportunity for observing the affective response of the mother to the child would be available; therefore some technique of eliciting response which would give cues to the family-child or mother-child relationship had to be developed.

The most obvious area for gathering data was the developmental history of the child. Here, pre-natal and birth conditions were important to record. Facts about the birth of the child and his early health, in addition to any specific eating or sleeping problems were needed. Toilet training, childhood illnesses, both chronic and temporary, and hospitalizations could also be noted. The child's relationship to the family, other adults and to sib and peers were additional sources of queries. The method of discipline employed, evidence of consistency, and the parent's perception of the child's progress in school and specific learning needs were listed as other areas of information gathering. Involvement in religious activities, marital status and leisure time activities were also included for information. In addition to these objective facts a list of stimulus questions was developed which was to be used by the social worker to elicit responses with affective content. Some examples of these are as follows:

1. Are there any early photographs of the child, or a baby book with his early life history?
2. What is the routine at bedtime?
3. Do you ever read to the child?
4. What did you do when your child cried when he was a baby?
5. How do you feel about sex education in school?
6. How do you feel about teaching religion in school?
7. What do you feel that the school should do about troublemakers?

The important area of socio-economic factors was recorded by direct observation and questioning. A review of some of the objective procedures for arriving at an indices of socio-economic status was made. Warner's (132) procedure for using housing, occupation, source of income and neighborhood was selected since a weighting of ratings on each of these factors was suggested and a distribution of scores related to socio-economic status was available. The criteria for housing, neighborhood and occupation level were used as suggested by Warner, and provided for ready reference for the social worker along with the interview materials.

All of these data were summarized mentally by the social workers when they were asked to make out a summary sheet which recorded the evidence of any genetic, environmental or psychological factors which could be related to a child's problem in school. The "Summary of Social Worker's Interview" was added at the end of the schedule to assist the worker in organizing the multitude of data collected. Finally the social worker was asked to make qualitative judgments about the child's status from inferences from the interview data and the summary. The qualitative judgments which the social workers felt that they could make from their visit in the child's home are as follows:

1. This child has serious physical problems (handicaps, psychosomatic disorders, general health problems)
2. This child's development has shown deviant psychological patterns (deprivation, rejection, hostility, etc.)
3. The social environment (housing, neighborhood, cultural values of family, peer relations, etc.) in which the child lives has been conducive to poor development
4. This is a family which would produce a child with serious learning and behavior problems
5. This child has serious personality problems
6. This child has school adjustment problems
7. This child has school learning problems

The complete social worker's interview schedule can be found in the Appendix. On it, information was collected by all the social workers in uniform fashion. The entire interview was arranged so the data could be collected in an average time of one hour.

G. The Procedures followed in making the individual appraisals

Following the many conferences needed to develop the interview and testing schedules the clinicians determined as finitely as possible the procedures which they would all use to gather data. Naturally the personality and individual approach of each clinician has something to do with exactly how he presents material to a subject; nevertheless the interview schedule and stimulus questions and materials were held as constant as possible so comparisons in findings could be made.

1. The Home Visit by the Social Worker

As mentioned previously, the social worker had the responsibility of picking up where the initial contact with the parent had been made by the school. In most cases the social worker contacted the parent directly, making an appointment with the mother at a time which was convenient. Each worker than went directly to the home to conduct the interview. The first objective of the interview was to explain in detail the nature of the project and to gain permission from the parent for the child to participate. Once permission was given, the interview was then conducted along the lines of the interview schedule. Each social worker began the interview with the question, "Is there anything the school can do to help your child which it is not doing?" This item was selected because it focused on school learning and made a good starting point for discussing aspects of the child's history which might be related to how he was progressing in his classes. The interview schedule was followed usually in the order of the items as they were listed. The interviews involved one or more parents, usually the mother, and the child was sometimes seen when and if he came home from school during the progress of the interview. In all cases, the persons present during the interview were recorded. The stimulus questions, to get affective responses, were covered at the end of the interview. The last item to be gathered by the social worker was the signed permission slip from the parents which made it possible for the school to schedule the child for psychological testing and psychiatric interviewing. A copy of the permission slip can be found in the Appendix. The number of parents who refused to participate once the social worker had arrived to gather the interview data is reported elsewhere.

2. Procedures for Psychological Testing

The psychologist was sent a list from the project office of names of children whose parents had signed the permission slip. They made their appointments for testing directly with the school principal.

The psychologist arrived at the school and was assigned to a vacant room for the testing. This was the nurse's office or the principal's office if there was no other available space. School principals are accustomed to having testing done at the school so they provided the area which would be provided for a school psychologist who had come for the same purpose.

The children were sent by messenger to the principal's office where the principal introduced them to the psychologist. Sometimes older children came directly to the testing room and took a note back to class to summon the next child. In most cases recesses and lunch hours were recognized. While there were minor variations in the procedure used to introduce the subject, most psychologists followed the pattern reported by Dr. Zimmerman which she recorded as follows:

"Introduction: 'Hello, I am Doctor Zimmerman, and I will be showing you some tests. When is your birthday? And how old are you now?'

"WISC: 'Fine. Let's see what kind of things you know.' Information, Comprehension, Similarities, Picture Completion, Block Design. Each subtest briefly introduced. At inappropriate or high level questions, face-saving devices were offered ('You haven't had that yet? -- That isn't taught 'til next year?'), and the child's ability to utilize these noted.

"Rorschach: 'Now here are some pictures that were made by dropping paint or ink on paper and folding it over to make a design. Have you ever done that? (Most had). They aren't anything, really, just designs, but they usually remind you of something; they make you think of something. Tell me what they look like to you. Here's the first one. Will you hold it?' After the first response, 'Anything else?' continued through the first few cards if the child did not give responses freely. Refusals were not accepted, and the child was urged to guess what it might be, for at least a minute. An inquiry followed. No testing the limits, except for pointing out the 'bow' area on III and the 'bears' area on VIII, and asking what they might be, during the inquiry. Not scored. Most and least liked card also requested.

"Bender: 'Now, let's see if you can copy some designs, one at a time, as well as you can. Here's the paper and a pencil, and here's the first one.'

"Termination: 'Thank you ! You may return to your class.'

"Running notes of behavior were taken throughout the examination. First notes were taken at the Birthday question. Accuracy and any remarks were noted. First signs of acting out, impulsive behavior were often seen here ('No one will tell me! My brother had a party--.'). During WISC Information, I recorded initial notes on looks, grooming, and behavior toward introduction to a school-like task. All remarks of the child were listed, and deviant responses flagged, including the number of questions necessary to elicit a response, and the point at which the child refused to respond ('I don't know'). Willingness to guess, upon urging, was noted. Passivity, dependency, defensiveness, brashness, and the like, were often clearly established by the time the child had finished the WISC (15 minutes).

"During the Rorschach, card treatment could be noted, and initiative established. For example, at what point the child began to put each blot face down upon completion as the examiner had the first. Freedom of communication and fantasy, and ability to communicate his ideas were studied here.

"During the administration of the Bender, paper and card placement were noted, as were running comments of the child as to 'meaning' or difficulty of each design. Slow, laborious reworking of the designs could be observed in some of the children. Such children would be assumed to be equally slow or perfectionistic in the classroom.

"As an examiner, I present myself to the child as a teacher surrogate, authoritarian, supportive, interested in how the child reaches his response. I discourage acting out, and ask the child to remain seated if he rises. Extraneous comments are kept to a minimum, so that the child is encouraged to approach the test in a workmanlike manner. Shy, hesitant children are encouraged and praised, while brash youngsters are restrained by teacher-like control gestures. The necessity for either such approach is noted, and so is the point in the battery where this becomes necessary. Acknowledgment of boredom and fatigue are freely offered, and most children seemed to find testing a pleasant break in school routine."

3. Procedures for Psychiatric Testing

In addition to the interview schedule discussed previously, the psychiatrists, before they began their work in the school, selected a number of items which were to become part of a portable play-kit. The play-kits were purchased in "five and ten cent" stores and placed in large attractive cardboard suitcases. In all kits the items were the same. They included:

Five hand puppets - a father, mother, boy, girl, and an animal
A toy doctor's kit
Beads and cord for stringing them
Play dough
Girl's make-up kit
Pop-gun
Balloon which could be blown up for a punching toy
Crayons and paints
Paper
Candy and gum
Checkers

Similar to the procedure used for making appointments for the children to see the psychologist, the psychiatrist was sent names of pupils for whom permission slips had been received by the project office. He went to the school on previously scheduled days and was established in some available room for his interviewing. Psychiatric interviewing is not usually done in school settings; this fact was one which the psychiatrists wished to have noted in the final report. Whatever differences this may have made in their experiences will have to be evaluated later.

The children came to the interviewing room or to the principal's office following a call taken by a messenger to the child's classroom. If the child came to the principal's office, he and the psychiatrist walked together to the setting for the interview. In the interview room, the objects of the play-kit were placed about, some close by, others at a distance, and some were left in the case. Both adult-sized and child-sized chairs were present. The opening gambit which the psychiatrist decided to use was, "Do you know why you're seeing me?" And then, "I am Dr. Weatherly. I want to find out as much as I can about children your age; what you think about; what you like; how you feel and so forth. Tell me what it would be important for me to know about children your age." The following description by Dr. Weatherly sums up the procedure used by the psychiatrists in conducting their interview:

"If not already standing, I always arose and met the child and then stood in a neutral place while he decided whether and where to sit. Almost at once I seized the opportunity to say with little modification from child to child, something like this: 'Did you know before now that you were going to have a chance to talk with me? Do you know what kind of doctor I am and why we are talking together today? Well, I'll tell you first the kind of doctor I'm not. I'm not the kind of doctor who gives shots or who examines teeth or eyes or who takes out tonsils. I'm a psychiatrist. Do you know what a psychiatrist is? He's the kind of doctor who is interested in how boys and girls feel - not how their bodies feel - but how they feel inside - whether they are mostly sad or angry or frightened or worried or troubled. He's the kind of doctor who wants to know about how people feel about themselves and about other people, their teachers and families and so on. I'm interested in knowing more about children your age. How do you feel? Do you have any troubles or worries or problems?'

"From this point on, interviews varied depending not only on what the child said in response to the above, but on how he appeared and acted. I placed as much or more significance on non-verbal as on verbal communication with particular emphasis on this when the two did not jibe. I used the toys only if the child went spontaneously to them or if he had obvious or implied discomfort in a verbal relationship with me, in which case I would remind him that we need not talk but could work or play with 'the things' I had. If he was acutely uncomfortable, I would insist that the child have a look at the toys and find something he'd like to do while we spent some time together 'getting acquainted.'

"With fifth-graders only and only when the child appear to 'understand' psychiatrists and their work somewhat, I would structure as follows: 'We are talking to many children to see if we can understand why some do so well in school and why others have trouble of one kind or another, so if possible, we can be of help to those who need it. What do you think.' Sooner or later in every case, second or fifth grade, I structured myself as a potentially helpful, or helping person and asked directly, 'Is there something or anything you need help with?'

"Though I usually resorted to such questions as 'How's school?' and 'What do you want to be?' and asked second graders for the '3 wishes' and fifth graders 'If there were just one thing in the whole world you could have changed or different to make your life better for you, what would it be?'- I had no 'set' of questions and very much took my cues from the child, getting involved with him in whatever he seemed to have most emotional investment in at the moment. I never failed to ask, and if necessary, to press for a dream, i.e., 'But try to remember - everyone has dreamed sometime, tell me even if it seems silly, etc.'

"I used 'Personalization' never hesitating to comment on the obvious such as 'How did you get your scar?' 'How beautifully you're dressed!' 'What is it like to wear dental braces?' I used what many would call a 'dynamic' approach or even an 'aggressive' approach though the essence of it is psychoanalytic-medical. For example, I let the child know that I was there for a purpose and I insisted that within the limits of his tolerance we do something meaningful. The idea that I tried to communicate was 'if you're shy, let's try together to understand about shyness and why, etc.', including those things which are not apparent, rational or reasonable. If we didn't get anywhere in the length of time which I spent with each child, I had the impression that we weren't going to get much more material in less than many interviews."

Even though each psychiatrist had a slightly different approach to the interviewing task, the procedure described above was similar to that reported by others.

H. Method Used in collecting quantitative and qualitative data on the project pupils

Each clinical group used the prescribed interview schedules in collecting the needed information on the project pupils. In each case the procedures were kept as uniform as possible, This was accomplished primarily by several regular sessions with the clinical groups in order to discuss problems and methods and to compare notes on the exact procedures which were being followed. Three types of data were collected on each of the project pupils. The first were the "hard" quantitative data collected on the interview schedules. The second were the "soft" qualitative judgments of a ranking of each pupil on the statements which were selected prior to the start of the clinical interview process. The third type of data were over-all judgments of school adjustment status using the same criteria as teachers had used in making the original ratings. A more detailed description of these methods follows:

1. Collection of quantitative data on interview schedules

In the case of each clinician, whether social worker, psychologist or psychiatrist, the interview schedule comprised a model for the conduct of the interview and contained the facts about the family and child which were to be routinely recorded. Codes for each of these data were decided upon in advance. If codes did not fit the obtained information, the clinician recorded what information he was given and additional coded classifications were later added by the project office. For the social worker, facts about birth, early life history, relationship with peers and adults comprise the type of information collected on the schedule. These are facts or observations which can be considered to have relatively high reliability since another worker using the same schedule presumably would get quite similar answers. The embellishments provided by the mother in answer to the question were used by the social worker to amplify the parent-child relationship patterns, to get some clue as to the place for the child in the family, and to obtain some idea as to his relationship to other members of the household.

The psychologists, in giving a routine psychological examination, recorded scores on WISC sub-tests, Bender design deviations and the scores on the Rorschach performance according to the Klopfer (62) scoring procedure. In addition to these objective facts, they made note of adaptive and maladaptive behavior during the testing situation, noting only whether the behavior was absent (or not manifest during the test interview), present, or present to a marked degree. These data were utilized later when the psychologists made a judgment of the child's behavior in the regular classroom situation. The comments made by the child during the interview were recorded on the protocols, and used in amplifying the importance of particular test findings when the qualitative ratings were made.

The psychiatrists, with a much less structured interview setting than either social worker or psychologist, were asked to make routine observations of the child's appearance, physical condition, general behavior, symptoms, reaction to the interview situation and so forth. These were recorded usually after seeing the child on the form established by the psychiatrists prior to the onset of the interview process.

2. Procedures for making qualitative judgments

The instructions to clinicians for making qualitative judgments, after interviewing no less than 20 pupils, were the same for all clinical groups. The task was to use a grid with five columns and as many rows as needed (ten rows were on the original form) to distribute the pupils for each qualitative judgment on a scale from one to five. A judgment of one was made when the clinician believed a particular child to be the most free from the trait listed. A judgment of five was made when the clinician believed the child to be least free from that trait and one with serious difficulties in the area being judged. Contrary to the instructions to teachers for making the original teacher rating, no pre-established form of the distribution of ratings was given. The task was to select from a sample of a minimum of twenty pupils of the same grade level, at least one who was to be placed in column one and at least one to be placed in column five. Once these two anchor pupils were located from the sample on a particular qualitative judgment, the process was to list any others who were similar in that particular trait to the anchor in the same columns and then to find those who were more or less similar and place them in squares in columns two, three or four. The same procedure was repeated for each qualitative judgment. A new grid with fifty squares (five columns and ten rows) was used and new anchors were found. It was possible that the same pupil was an anchor pupil for more than one qualitative judgment, but this was not usually the case. Only when a clinician saw fewer than 20 pupils at one grade level was the distribution narrower than the required five ratings. A sample booklet in which such judgments were made is included in the Appendix.

This procedure for making qualitative judgments resulted in each pupil having 25 judgments, seven from the social worker, eleven from the psychologist and seven from the psychiatrist, on a scale of from one to five. Each of these judgments was made independent of one another. Following the qualitative rating procedure, the clinician was required to review the pupils who were placed as anchors in the one, three and five columns, and list a number of descriptive adjectives from his case material which could be then formulated into the criteria for making the rating. While the procedures of this project made it impossible for two clinicians to interview a common sample of parents or pupils, the distributions of their ratings, and their average ratings for each judgment were compared in order to detect any important biases which might have crept into their judgments. Where any marked differences did occur, differences in the location of the school or possible pupilation variables seemed better able to account for the discrepancy than actual bias in the clinical judgment. This is recognized as a weak substitute for a measure of the reliability of clinical judgment; nevertheless, the notion that clinical bias was kept to a minimum seems justified. Tables V through X contain the distribution of all qualitative judgment ratings by each clinical group for each grade level.

3. Making the final, collaborative judgment of school adjustment

Prior to the time that the final judgment of school adjustment was to be made, none of the clinicians had had any opportunity to share information or data collected on children whom they had interviewed in common. No data were made available to the teams from the school files, and teachers and principals were instructed not to divulge revealing information on any of the pupils. Therefore, the data to this point in the project are considered to be uncontaminated, each clinical group operating with only the information which was collected by its interview guidelines. A final judgment of school adjustment based on all the clinical data collected by the teams was needed as one of the criterion measures. When all the qualitative judgments on the project pupils had arrived in the project office, they were placed on large sheets opposite the statement describing the judgment. Every pupil of the same grade who was seen by a team of social worker, psychologist, and psychiatrist was listed along with all of his ratings. Four copies of this material were made. One copy went to each clinician and one was kept for office records. This listing of pupils with qualitative judgments was then sent along with the criteria used by teachers in making the initial judgment of school adjustment status and another grid with five columns and ten rows for making the final judgment of school adjustment. Each clinician then compared the ratings made on a particular pupil by the two other members of the team with those which he had made and made a single distribution of all the pupils on a scale of school adjustment using the criteria which were supplied to teachers. Three other questions were also to be answered at this time. They were selected because they added a general diagnostic statement, a prognostic statement and an indication of whether the child was felt to be one who needed psychotherapy. The questions were as follows:

1. Is this a troubled or troublesome child? (diagnostic)
2. Does this child need a referral for psychotherapy?
3. What is this child's ability to manage his life in the future? (prognostic)

The ratings on these statements were not distributed on a rating grid, but made according to instructions provided on the final judgment booklets. A sample booklet for making over-all judgment of school adjustment is provided in the Appendix.

I. Characteristics of Qualitative judgments made by Clinicians

When the smoke had cleared and it was possible to determine the exact number of pupils who were given clinical evaluations at the end of the criterion phase of the project, 75 second grade girls, 75 second grade boys, 55 fifth grade girls and 95 fifth grade boys were scheduled for interviews by the clinical teams. Even though the original listing attempted to equate the number of boys and girls at each grade level, differences in original teacher ratings at fifth grade, giving a greater number of negative ratings to boys rather than to girls, resulted in a discrepancy between the number of girls and boys at the fifth grade level. Some deviation in sample size occurred when an appointment with a clinician was missed by a particular pupil which could not be scheduled at a later time. In other cases, after the case file was completed, the pupil moved from the school before participating in the screening process. These sampling problems result in slight variations from the Ns quoted above for any of the comparisons which are discussed in this part of the report. In any case the variations in sample number, where they did occur for a particular set of data, are so small (from 1 to 4 pupils) that it is simplest for the reader to consider each sample N as noted above.

1. Distributions of Ratings made by the Clinical Teams

The first step in analyzing the process of obtaining clinical ratings of behavior and personality judged by the clinicians was to compare all of the psychologists, social workers and psychiatrists with one another to see whether the distributions of their judgments were markedly different. Even though the shapes of the distributions and the criteria used for each judgment are comparable, certain differences are worthy of note.

a. Distributions of Qualitative Judgments made by Social Workers

Tables V and VI contain the distribution of each of the qualitative judgments made by the social workers for second grade and fifth grade pupils. By comparing the distributions of social worker 1 through 6, it is possible to note differences between tham in terms of the underlying distribution which each assigned to a particular trait. The average ratings for each item varied from 2.1 to 3.4 for second grade pupils and 1.9 to 3.5 for fifth grade students. Some differences between social worker averages can be found which are worthy of note. First the two judgments which resulted in the greatest variability of average ratings for both second and fifth graders were "This child's development has shown deviant psychological patterns," and "This family might produce a child with serious learning and behavior problems." It is impossible to determine with the available data whether or not this variability is a result of differences in the populations seen by the social workers or whether each worker weighted information gained from the interview differently. One inference may be that regardless of whether there were differences in social workers or differences in populations, the significance of data collected about the psychological environment for a child is difficult to interpret. Smaller variability is found in judgments of the physical status of the pupils, item 1, or judgments of the social environment, item 3. However, in the case of physical health or the adequacy of the social environment, some types of normative data are available for the general population on what constitutes a physical problem or what would be characteristic of an inadequate social environment. Lacking comparable normative data for what constitutes deviant psychological development or problem families apart from characteristics of extreme cases which can be found in any social worker's case book, it may be more difficult for the social workers to arrive at consistent distributions of judgments. In any case, the fact that the populations of the different schools may have been different in these characteristics must be considered as one explanation of these results.

b. Distributions of Qualitative Judgments made by Psychologists

The most obvious difference between the distribution of psychologists' ratings from those made by the social workers is in the greater degree of normality of the psychologists' distributions. For both grade levels, even though the range of psychologists' average ratings for items runs from .4 to 1.0, the averages are all close to 3.0 with the ratings lying in approximately equal numbers on both sides of the average rating. The distributions of social workers show fewer ratings on the negative side of the grid, especially in the column for ratings of "5", and a greater proportion can be found on the positive side of the average (rating 1 or 2). One explanation for this difference in ratings between those made by social workers and those made by psychologists may be found in differences in their

TABLE V

Frequency of Ratings and Average Rating Of All Qualitative Judgments Made By Social Workers Of Second Grade Boys and Girls

	Frequency of Rating						
	1	2	3	4	5	Total	Average Rating
1. This child has serious physical problems							
Social Worker Code							
1	15	13	9	6	5	48	2.3
2	3	1	5	5	1	15	3.0
3	4	11	8	10	2	35	2.9
4	1	3	9	3	3	19	3.2
5	4	6	5	5	1	21	2.7
6	3	2	4	2	0	11	2.5
Total all Social Workers	30	36	40	31	12	149	2.72
2. This child's development has shown deviant psychological patterns							
Social Worker Code							
1	23	8	6	8	3	48	2.1
2	3	2	5	4	1	15	2.9
3	3	11	7	13	1	35	3.0
4	1	2	8	4	4	19	3.4
5	4	7	6	3	1	21	2.5
6	2	6	2	1	0	11	2.2
Total all Social Workers	36	36	34	33	10	149	2.63
3. The social environment is conducive to poor development							
Social Worker Code							
1	11	11	15	7	4	48	2.6
2	3	3	4	3	2	15	2.9
3	1	11	8	14	1	35	3.1
4	2	7	7	2	1	19	2.6
5	4	4	7	3	3	21	2.9
6	1	7	2	1	0	11	2.3
Total all Social Workers	22	43	43	30	11	149	2.77
4. This family might produce a child with serious learning and behavior problems							
Social Worker Code							
1	9	11	13	12	3	48	2.8
2	3	3	2	4	3	15	3.1
3	1	6	13	14	1	35	3.2
4	2	1	7	6	3	19	3.4
5	3	6	6	4	2	21	2.8
6	2	5	2	2	0	11	2.4
Total all Social Workers	20	32	43	42	12	149	2.96

TABLE V
Page 2

Frequency of Rating

	1	2	3	4	5	Total	Average Rating
5. This child has serious personality problems							
Social Worker Code							
1	10	18	7	10	3	48	2.5
2	3	3	4	3	2	15	2.9
3	2	10	14	8	1	35	3.1
4	1	2	9	5	2	19	3.3
5	2	8	6	4	1	21	2.7
6	1	5	4	1	0	11	2.5
Total all Social Workers	19	46	44	31	9	149	2.77
6. This child has school adjustment problems							
Social Worker Code							
1	12	18	9	5	4	48	2.4
2	2	5	4	2	2	15	2.8
3	3	10	16	5	1	35	2.8
4	2	4	7	5	1	19	2.9
5	4	8	6	2	1	21	2.4
6	0	2	9	0	0	11	2.8
Total all Social Workers	23	47	51	19	9	149	2.62
7. This child has school learning problems							
Social Worker Code							
1	10	12	14	6	6	48	2.6
2	2	4	3	3	3	15	3.1
3	3	8	17	6	1	35	2.6
4	4	4	5	5	1	19	2.9
5	7	3	5	2	4	21	2.7
6	2	6	2	1	0	11	2.2
Total all Social Workers	28	37	46	23	15	149	2.73

TABLE VI

Frequency of Ratings and Average Rating Of all Qualitative Judgments Made by Social Workers Of Fifth Grade Boys and Girls

	Frequency of Rating						
	1	2	3	4	5	Total	Average Rating
1. This child has serious physical problems							
Social Worker Code							
1	7	26	14	15	1	63	2.6
2	2	2	2	4	2	12	3.2
3	2	12	7	5	1	27	2.2
4	2	3	9	5	2	21	3.1
5	4	5	4	2	2	17	2.6
6	1	5	3	2	0	11	2.5
Total all Social Workers	18	53	39	33	8	151	2.74
2. This child's development has shown deviant psychological patterns							
Social Worker Code							
1	21	18	16	4	4	63	2.2
2	2	2	4	2	2	12	3.0
3	1	4	10	11	1	27	2.7
4	2	2	7	7	3	21	3.3
5	2	4	4	5	2	17	3.1
6	1	4	6	0	0	11	2.5
Total all Social Workers	29	34	47	29	12	151	2.74
3. The social environment is conducive to poor development							
Social Worker Code							
1	21	17	17	6	2	63	2.3
2	2	3	3	2	2	12	2.9
3	2	5	7	12	1	27	2.7
4	2	5	12	1	1	21	3.0
5	2	5	5	3	2	17	2.9
6	0	6	3	2	0	11	2.6
Total all Social Workers	29	36	47	26	8	151	2.56
4. This family might produce a child with serious learning and behavior problems							
Social Worker Code							
1	19	19	16	7	2	63	2.6
2	2	2	4	2	2	12	3.0
3	1	2	12	12	0	27	2.9
4	3	2	4	7	5	21	3.4
5	1	3	4	5	4	17	3.5
6	0	6	3	2	0	11	2.5
Total all Social Workers	26	34	43	35	13	151	2.83

	Frequency of Rating						
	1	2	3	4	5	Total	Average Rating
5. This child has serious personality problems							
Social Worker Code							
1	18	17	19	4	5	63	2.3
2	2	2	4	2	2	12	3.0
3	1	5	12	8	1	27	2.8
4	4	4	7	4	2	21	2.8
5	4	4	4	3	2	17	2.7
6	2	3	4	2	0	11	2.5
Total all Social Workers	31	35	50	23	12	151	2.67
6. This child has school adjustment problems							
Social Worker Code							
1	29	19	9	5	1	63	1.9
2	2	2	4	2	2	12	3.0
3	1	6	18	1	1	27	2.4
4	2	4	11	3	1	21	2.9
5	2	8	1	5	1	17	2.7
6	1	1	7	2	0	11	2.9
Total all Social Workers	37	40	50	18	6	151	2.44
7. This child has school learning problems							
Social Worker Code							
1	14	9	25	10	5	63	2.7
2	2	2	2	4	2	12	3.0
3	1	7	11	6	2	27	2.5
4	6	4	8	2	1	21	2.4
5	4	4	4	3	2	17	2.7
6	1	3	6	1	0	11	2.6
Total all Social Workers	28	29	56	26	12	151	2.77

professional training. Psychologists are more measurement oriented, and therefore can be expected to arrive at more nearly normal distributions of ratings. Social workers, with their emphasis on qualitative evaluation of case material, may not be so bound to normal distributions and feel quite comfortable ranking pupils in any pattern which seems to fit the sample. If the explanation is not to be found in the training, the fact may be that the psychologists' ratings lend themselves to more normal distributions and often have fairly well established criteria for test behaviors which are above and below average for grade. Again, differences in populations or differences in clinicians must be considered as explanations of the results noted in Tables VII and VIII.

c. Distribution of Qualitative Judgments made by Psychiatrists

The over-all variability in distributions of psychiatrists' ratings is greater than in the case of either social workers or psychologists. Greatest variability in psychiatrists' ratings can be found in item 6, both at second and fifth grade - "This child has appropriate contact with and relationship to reality." Here again as in the case of social workers, few normative data are available on this trait which would allow a psychiatrist to make judgments of what is typical for an age, what is better than expected and what is poorer. While the criteria which psychiatrists used were found to be quite consistent, the problem comes when the psychiatrist makes a determination of how significant a particular finding is in a particular case. The psychiatrist must ask himself, "Is this typical for the age?" or "Is this typical of children in a particular developmental sequence?" or "Is this an indication of some pathology?" The task of arriving at consistency in ratings from psychiatrist to psychiatrist is difficult at best, but made even more difficult in the task assigned to them here in that no outside information was made available which could assist them in evaluating a particular observation against data collected by other workers. When collaborative ratings were made later, all clinical groups improved their predictive judgments. Tables IX and X contain the distributions for all psychiatrists for each of the ratings.

2. Relationship between Clinical Judgments and original Teacher Rating

The final judgment of school adjustment status at which the clinician arrived after a review of the ratings made by his colleagues for all of the pupils he saw can be compared to the original teacher rating of school adjustment status made by teachers who had had the same pupils one year prior to the time that the clinicians made their final rating of school adjustment status. Since the clinicians used the same criteria as the teacher had used in arriving at this judgment, it is legitimate to compare teachers and clinicians on the degree to which they agree on the pupils with good and poor school adjustment. When making such comparisons, however, one must remember that school adjustment is not a static trait and that pupils may be expected to vary from time to time in the degree to which they manage their school lives as well as can be expected. The correlations between final judgment of school adjustment status and the original teacher judgments of school adjustment can be found for each clinical group on Table XI. In addition the correlations of all qualitative judgments with the original teacher rating are also listed. Asterisks indicate those correlations which are better than chance at the 5% level of significance based on appropriate degrees of freedom for each sample.

TABLE VII

Frequency of Ratings and Average Rating Of all Qualitative Judgments made by Psychologists Of Second Grade Boys and Girls

	Frequency of Rating						
	1	2	3	4	5	Total	Average Rating
1. This child has poor intellectual functioning							
Psychologist Code							
1	2	8	12	5	2	29	2.9
2	5	6	8	6	5	30	3.3
3	1	2	0	3	2	8	3.5
4	5	6	9	3	3	26	2.7
5	9	9	20	11	5	54	2.9
Total all Psychologists	22	31	49	28	17	147	2.91
2. This child has severe perceptual difficulties							
Psychologist Code							
1	3	2	13	9	2	29	3.2
2	6	6	10	3	5	30	2.8
3	1	1	1	3	2	8	3.5
4	5	7	6	5	3	26	2.8
5	5	10	18	16	5	54	3.1
Total all Psychologists	20	26	48	36	17	147	3.03
3. This child has severe personality disturbance							
Psychologist Code							
1	3	4	12	7	3	29	3.1
2	6	6	7	6	5	30	2.9
3	1	1	2	2	2	8	3.4
4	1	1	10	9	5	26	3.6
5	5	12	18	14	5	54	3.0
Total All Psychologists	16	24	49	38	20	147	3.15
4. This child has problems relating to classroom teacher							
Psychologist Code							
1	2	6	15	4	2	29	2.9
2	6	5	8	6	5	30	3.0
3	2	1	0	2	3	8	3.4
4	1	6	8	9	2	26	3.2
5	4	10	22	12	6	54	3.1
Total All Psychologists	15	28	53	33	18	147	3.07
5. This child meets learning tasks effectively							
Psychologist Code							
1	2	6	7	12	2	29	2.8
2	5	4	9	6	6	30	3.1
3	1	2	0	2	3	8	3.5
4	3	4	8	7	4	26	3.2
5	8	12	13	13	8	54	3.0
Total All Psychologists	19	28	37	40	23	147	3.14
6. This child has creative potential							
Psychologist Code							
1	4	5	13	4	3	29	2.9
2	6	6	6	8	4	30	2.9
3	0	2	2	2	2	8	3.5
4	1	5	9	7	4	26	3.3
5	6	11	18	14	5	54	3.0
Total All Psychologists	17	29	48	35	18	147	3.05

TABLE VII
Page 2

Frequency of Rating

	1	2	3	4	5	Total	Average Rating
7. This child has poor school adjustment Psychologist Code							
1	2	7	14	4	2	29	2.9
2	5	7	8	5	5	30	2.9
3	0	2	2	1	3	8	3.6
4	2	4	6	9	5	26	3.4
5	5	11	20	13	5	54	3.0
Total all Psychologists	14	31	50	32	20	147	3.39
8. This child has poor school achievement Psychologist Code							
1	2	6	12	7	2	29	3.0
2	4	5	8	7	6	30	3.2
3	1	2	1	1	3	8	2.7
4	4	6	9	3	4	26	2.9
5	7	11	19	11	6	54	3.0
Total all Psychologists	18	30	49	29	21	147	3.03
9. Over-all Rating of WISC Psychologist Code							
1	2	7	13	5	2	29	2.9
2	6	5	8	7	4	30	2.9
3	0	1	2	3	2	8	3.8
4	3	8	9	3	3	26	2.8
5	8	10	20	11	5	54	2.9
Total all Psychologists	19	31	52	29	16	147	2.95
10. Over-all Rating of Bender Psychologist Code							
1	3	2	12	10	2	29	3.2
2	7	6	8	4	5	30	2.8
3	1	1	3	2	1	8	3.1
4	3	4	5	9	5	26	3.3
5	5	10	20	14	5	54	3.1
Total all Psychologists	19	23	48	39	18	147	3.10
11. Over-all Rating of Rorschach Psychologist Code							
1	3	3	13	7	3	29	3.1
2	5	6	7	6	6	30	3.1
3	1	2	1	2	2	8	3.3
4	1	2	7	9	7	26	3.5
5	5	10	20	15	4	54	3.1
Total all Psychologists	15	23	48	39	22	147	3.20

TABLE VIII

Frequency of Ratings and Average Rating
Of all Qualitative Judgments made by Psychologists
Of Fifth Grade Boys and Girls

	Frequency of Rating						
	1	2	3	4	5	Total	Average Rating
1. This child has poor intellectual functioning							
Psychologist Code							
1	2	5	6	4	4	21	3.1
2	5	5	6	4	4	24	2.9
3	3	3	11	7	2	26	3.1
4	4	3	4	3	2	16	2.7
5	11	13	27	10	4	65	2.6
Total All Psychologists	25	29	54	28	16	152	2.81
2. This child has severe perceptual difficulties							
Psychologist Code							
1	1	5	11	3	1	21	2.9
2	5	5	7	4	3	24	2.8
3	1	2	11	10	2	26	3.4
4	4	3	4	3	2	16	2.7
5	10	10	25	12	8	65	3.0
Total All Psychologists	21	25	58	32	16	152	2.91
3. This child has severe personality disturbance							
Psychologist Code							
1	1	6	7	6	1	21	3.0
2	4	4	8	4	4	24	3.4
3	1	1	9	10	5	26	3.7
4	1	2	6	4	3	16	3.4
5	4	15	23	17	6	65	3.1
Total All Psychologists	11	28	53	41	19	152	3.19
4. This child has problems relating to classroom teacher							
Psychologist Code							
1	2	4	9	4	2	21	3.0
2	4	4	8	4	4	24	3.4
3	1	5	7	9	4	26	3.4
4	3	3	5	3	2	16	2.9
5	8	13	24	16	4	65	2.9
Total All Psychologists	18	29	53	36	16	152	3.02
5. This child meets learning tasks effectively							
Psychologist Code							
1	2	5	5	7	3	21	3.1
2	5	5	6	4	4	24	2.9
3	1	5	10	7	3	26	3.2
4	2	4	7	2	1	16	2.8
5	9	13	26	11	6	65	2.9
Total all Psychologists	19	32	54	31	16	152	2.95
6. This child has creative potential							
Psychologist Code							
1	3	3	8	6	1	21	3.0
2	5	6	6	3	4	24	2.8
3	2	7	11	4	2	26	2.9
4	1	7	6	1	1	16	2.6
5	9	19	20	12	5	65	2.8
Total All Psychologists	20	42	51	26	13	152	2.80

TABLE VIII
Page 2

	Frequency of Rating						
	1	2	3	4	5	Total	Average Rating
7. This child has poor school adjustment							
Psychologist Code							
1	2	6	9	2	2	21	2.7
2	4	5	6	5	4	24	3.0
3	1	1	8	10	6	26	3.7
4	2	4	5	4	1	16	2.9
5	7	13	25	16	4	65	3.0
Total all Psychologists	16	29	53	37	17	152	3.07
8. This child has poor school achievement							
Psychologist Code							
1	2	4	7	6	2	21	2.7
2	5	5	7	4	3	24	2.8
3	3	3	5	8	7	26	3.5
4	4	4	4	2	2	16	2.6
5	8	16	23	11	7	65	2.9
Total all Psychologists	22	32	46	31	21	152	2.98
9. Over-all Rating of WISC							
Psychologist Code							
1	2	5	6	4	4	21	3.1
2	6	5	5	4	4	24	2.8
3	2	4	8	10	2	26	3.2
4	4	2	7	2	1	16	2.6
5	10	15	24	11	5	65	2.8
Total all Psychologists	24	31	50	31	16	152	2.89
10. Over-all **Rating** of **Bender**							
Psychologist Code							
1	1	5	11	3	1	21	2.9
2	5	4	6	4	5	24	3.0
3	3	2	10	3	8	26	3.4
4	4	4	4	2	2	16	2.6
5	8	11	26	12	8	65	3.0
Total all Psychologists	21	26	57	24	24	152	3.03
11. Over-all **Rating** of Rorschach							
Psychologist Code							
1	1	6	7	6	1	21	3.0
2	4	6	6	4	4	24	2.9
3	1	2	6	11	6	26	3.7
4	2	5	5	3	1	16	2.8
5	7	12	23	16	7	65	3.1
Total all Psychologists	15	31	47	40	19	152	3.05

TABLE IX

Frequency of Ratings and Average Rating Of All Qualitative Judgments Made by Psychiatrists Of Second Grade Boys and Girls

Frequency of Rating

	1	2	3	4	5	Total	Average Rating
1. This child is comfortable with himself							
Psychiatrist Code							
1	7	7	4	7	1	26	2.6
2	2	8	9	3	0	22	2.6
3	5	5	7	9	3	29	3.8
4	8	4	6	3	5	26	2.7
5	3	9	13	7	2	34	2.9
6	1	4	3	3	0	11	2.7
Total all Psychiatrists	26	37	42	32	11	148	2.76
2. This child is comfortable with others							
Psychiatrist Code							
1	6	4	8	7	1	26	2.7
2	2	12	5	3	0	22	2.4
3	5	6	8	6	4	29	3.4
4	7	4	6	5	4	26	2.8
5	4	7	15	5	3	34	2.9
6	0	4	4	3	0	11	2.9
Total all Psychiatrists	24	37	46	29	12	148	2.78
3. This child has serious learning difficulties							
Psychiatrist Code							
1	6	8	6	4	2	26	3.0
2	1	4	15	2	0	22	2.8
3	2	3	9	6	9	29	2.8
4	8	6	6	5	1	26	2.4
5	3	10	13	6	2	34	2.8
6	1	4	2	3	1	11	2.9
Total all Psychiatrists	21	35	51	26	15	148	2.86
4. This child has serious behavior problems							
Psychiatrist Code							
1	5	9	11	1	0	26	2.4
2	4	12	6	0	0	22	2.1
3	5	4	7	7	6	29	3.0
4	10	8	6	1	1	26	2.0
5	5	8	15	4	2	34	2.7
6	2	3	2	4	0	11	2.7
Total all Psychiatrists	31	44	47	17	9	148	2.52

TABLE IX
Page 2

	Frequency of Rating						
	1	2	3	4	5	Total	Average Rating
5. This child needs help							
Psychiatrist Code							
1	3	8	6	8	1	26	2.9
2	0	6	9	7	0	22	3.0
3	6	5	4	10	4	29	3.6
4	9	5	5	4	3	26	2.5
5	4	5	15	8	2	34	3.0
6	1	4	2	3	1	11	2.9
Total all Psychiatrists	23	33	41	40	11	148	2.87
6. This child has appropriate contact with and relationship to reality							
Psychiatrist Code							
1	3	9	10	4	0	26	2.6
2	13	8	1	0	0	22	1.5
3	4	5	8	6	6	29	2.7
4	8	6	9	2	1	26	2.3
5	3	7	14	8	2	34	3.0
6	4	3	3	1	0	11	2.1
Total all Psychiatrists	35	38	45	21	9	148	2.53
7. This child has generally poor school adjustment							
Psychiatrist Code							
1	4	9	7	4	2	26	2.1
2	4	14	3	1	0	22	2.0
3	3	2	6	8	10	29	2.9
4	9	8	3	4	2	26	2.4
5	3	11	13	6	1	34	2.7
6	1	6	0	3	1	11	2.7
Total all Psychiatrists	24	50	32	26	16	148	2.73

TABLE X

Frequency of Ratings and Average Rating Of All Qualitative Judgments Made by Psychiatrists Of Fifth Grade Boys and Girls

	Frequency of Rating						
	1	2	3	4	5	Total	Average Rating
1. This child is comfortable with himself							
Psychiatrist Code							
1	2	1	7	5	1	16	3.2
2	2	6	6	5	0	19	2.7
3	3	3	7	23	11	47	3.7
4	5	6	9	6	5	31	3.0
5	3	6	12	4	2	27	2.9
6	0	4	6	1	0	11	2.7
Total all Psychiatrists	15	26	47	44	19	151	3.17
2. This child is comfortable with others							
Psychiatrist Code							
1	1	4	7	4	0	16	3.1
2	3	6	6	4	0	19	2.6
3	3	5	12	18	9	47	3.5
4	5	3	11	7	5	31	3.1
5	2	7	12	4	2	27	2.9
6	0	2	6	3	0	11	3.1
Total all Psychiatrists	14	27	54	40	16	151	3.11
3. This child has serious learning difficulties							
Psychiatrist Code							
1	2	3	5	4	2	16	3.3
2	3	6	6	4	0	19	2.6
3	4	9	13	18	3	47	3.3
4	6	10	7	6	2	31	3.0
5	2	6	9	8	2	27	3.1
6	0	4	4	2	1	11	3.0
Total all Psychiatrists	17	38	44	42	10	151	2.93
4. This child has serious behavior problems							
Psychiatrist Code							
1	0	6	8	2	0	16	2.8
2	5	7	4	3	0	19	2.3
3	6	9	16	14	2	47	2.9
4	9	9	7	5	1	31	2.3
5	2	8	12	4	1	27	2.8
6	0	3	5	3	0	11	3.0
Total all Psychiatrists	22	42	52	31	4	151	2.69

TABLE X
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Frequency of Rating

	1	2	3	4	5	Total	Average Rating
5. This child needs help							
Psychiatrist Code							
1	1	1	6	6	2	16	3.6
2	3	3	5	7	1	19	3.0
3	2	8	10	14	13	47	3.6
4	6	7	7	7	4	31	2.9
5	2	7	6	10	2	27	3.1
6	1	2	6	1	1	11	2.9
Total all Psychiatrists	15	28	40	45	23	151	3.22
6. This child has appropriate contact with and relationship to reality							
Psychiatrist Code							
1	1	5	6	1	3	16	2.8
2	14	5	0	0	0	19	1.3
3	2	15	11	15	4	47	2.5
4	7	11	6	5	2	31	2.5
5	2	7	6	10	2	27	3.1
6	4	4	3	0	0	11	1.9
Total all Psychiatrists	30	47	32	31	11	151	2.63
7. This child has generally poor school adjustment							
Psychiatrist Code							
1	3	4	5	3	1	16	2.6
2	5	9	1	4	0	19	2.2
3	4	10	17	13	3	47	3.1
4	6	9	9	5	2	31	2.6
5	2	7	12	4	2	27	2.9
6	0	3	6	2	0	11	2.9
Total all Psychiatrists	20	42	50	31	8	151	2.77

TABLE XI

Correlations of Original Teacher Rating Of School Adjustment with Qualitative Judgments Made by Clinicians

	GROUP			
	Second Grade Girls	Second Grade Boys	Fifth Grade Girls	Fifth Grade Boys
SOCIAL WORKER QUALITATIVE JUDGMENTS				
1. This child has serious physical problems	.297*	-.052	.255	.186
2. The development shows deviant psychological patterns.	.556*	.088	.286	.308*
3. Social environment conducive to poor school adjustment	.481*	.218	.221	.219*
4. Family might produce a child with problems.	.639*	.133	.317*	.166
5. Serious personality problems.	.491*	.126	.203	.187
6. School adjustment problems.	.492*	.250*	.370*	.272*
7. School learning problems.	.480*	.274*	.194	.374*
8. Sum of social worker qualitative judgments.	.605*	.198	.352*	.334*
9. Final social worker judgment of school adjustment.	.444*	.263*	.368*	.288*
10. Troubled or troublesome child.	.466*	.241*	.203	.218*
PSYCHOLOGIST QUALITATIVE JUDGMENTS				
1. Poor intellectual functioning.	.198	.468*	.288*	.188
2. Severe perceptual difficulties.	.301*	.513*	.477*	.119
3. Severe personality disturbances.	.131	.157	.254	.164
4. Problems relating to classroom teacher.	.254*	.432*	.248	.212*
5. Meets learning tasks effectively.	.188	.485*	.282	.174
6. Has creative potential.	.079	.269*	.246	.086
7. Has poor school adjustment.	.223	.444*	.261	.153
8. Has poor school achievement.	.272*	.478*	.240	.156
9. Over-all rating of WISC.	.262*	.478*	.240	.156
10. Over-all rating of Bender.	.316*	.426*	.464*	.076
11. Over-all rating of Rorschach.	.169	.110	.304*	.150
12. Sum of psychologist qualitative judgments.	.273*	.520*	.392*	.205*
13. Final psychologist judgment of school adjustment.	.192	.525*	.401*	.208*
14. Troubled or troublesome child.	.259*	.287*	.415*	.010
PSYCHIATRIST QUALITATIVE JUDGMENTS				
1. Is child comfortable with himself.	.076	.227*	.069	.261*
2. Is child comfortable with others.	.184	.207	.048	.253*
3. Has serious learning difficulties.	.210	.360*	.246	.387*
4. Has serious behavior problems.	.068	.384*	.249	.323*
5. Child needs help.	.116	.396*	.153	.347*
6. Has appropriate contact with and relationship to reality.	.154	.258*	-.067	.228*

TABLE XI
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	Second Grade Girls	Second Grade Boys	Fifth Grade Girls	Fifth Grade Boys
7. Generally poor school adjustment	.055	.359 *	.103	.367*
8. Sum of psychiatrist qualitative judgments.	.140	.369 *	.134	.389*
9. Final psychiatrist judgment of school adjustment.	.243*	.402 *	.276	.372 *
10. Troubled or troublesome child.	.239*	.407 *	.148	.407 *
COMBINED CLINICAL RATINGS				
Total of all qualitative judgments.	.418*	.543*	.412*	.358*
Total of all final judgments.	.357*	.503*	.421*	.422*

* Significant at 5% level

Note:

N = 75 second grade girls
N = 75 second grade boys
N = 55 fifth grade girls
N = 95 fifth grade boys

One can note that there is a moderately high and positive correlation between social worker, psychologist and psychiatrist judgment of school adjustment status and original teacher judgment in all samples, with two exceptions. The correlation of the psychologists' and teachers' judgment of school adjustment status fails to meet the 5% level for second grade girls. While the correlation between the psychiatrists' and teachers' judgment of school adjustment approaches the 5% level (.288), it fails to meet this criterion of difference from chance for fifth grade girls.

The qualitative judgments made by social workers appear to be most closely related to teachers' judgments of school adjustment for all samples with the best agreement to be found in the sample of second grade girls and fifth grade boys. Psychologists' judgments of second grade boys and girls appear to be most related to teachers' appraisal of school adjustment, but are not consistently in agreement at the fifth grade level. Psychiatrists' evaluations of pupils' behavior and personality were most related to teachers' evaluation of adjustment status for boys, but quite unrelated in the case of both second and fifth grade girls.

Appropriate inferences from these discrepancies between teachers' and clinicians' judgments of school adjustment status are difficult to draw at this point. Suffice it to say that teachers see pupils in a much different setting from that of the clinician, and each professional group is looking for different types of behavior from which to infer problems or lack of problems. Some of the differences between boys and girls may be related to the fact that clinicians typically see fewer girls in their general case work, and also the fact that teachers generally refer fewer girls to school guidance offices. Girls may be truly better adjusted in school than boys, but it may also be possible that maladjustment in girls may not reflect itself in undesirable school or classroom behavior. A great deal of careful study of the records of girls and boys in terms of agreements between perceived behavior of the classroom and the inferred psychological dynamics from clinical appraisal is needed before adequate illumination of this puzzle can be expected.

If all of the qualitative ratings assigned by clinicians, with the exception of their final judgment of school adjustment, are summed, the correlation between this sum and teachers' rating of school adjustment is quite significant for all samples. The sum of all qualitative judgments can provide a good criterion measure of school adjustment status if one considers its ability to predict teachers' judgments made one year earlier. This over-all sum of ratings weights all ratings equally so that some underlying behavior variables may contribute more than others to the total. A fairer criterion measure may be, then, the sum of the final ratings of school adjustment made by the clinicians. The correlation of this sum is a little lower for some samples than the sum of all ratings, but it is a weighted score since each clinician had to draw out of the data he was given and weight appropriately those qualitative judgments which he thought were most predictive of school adjustment. The means and standard deviations are as follows:

Sample	Sum of all Qualitative Judgments		Sum of Final Judgments of School Adjustment	
	M	S.D.	M	S.D.
Second Grade Girls	69.76	18.29	8.58	2.92
Second Grade Boys	73.44	16.72	9.26	2.81
Fifth Grade Girls	68.09	15.78	8.05	2.46
Fifth Grade Boys	75.17	15.93	9.42	2.61

3. Intercorrelations of Qualitative Judgments of Clinicians

Tables XII, XIII, XIV, XV, XVI, XVII provide the intercorrelations among qualitative ratings made by each clinical group and the correlations between qualitative judgments made by the clinical teams. By inspection of these tables one can see that there is generally a high positive intercorrelation between all of the psychological or social worker or psychiatric qualitative judgments, but a low, sometimes zero and occasionally negative correlation between qualitative judgments made by the clinical groups. One can infer that there is a generalized perception of pupils which underlies the ratings made by a particular discipline, but that the nature of this perception varies as a function of the intent of the clinician making an appraisal of the home situation, or an evaluation of a pupil in a standardized testing situation, or a diagnosis of the degree of personality problems from the more unstructured psychiatric interview. In other words, the data collected by psychiatrists, social workers and psychologists are probably separate and perhaps distinct pieces of information about pupils which may be, in many cases, unrelated to one another. Nevertheless the agreement between the clinical groups on the rating of the pupils' over-all school adjustment indicates that while the data collected by members of a clinical team are not consistently related, the weighting of these data in terms of a diagnostic prediction about school adjustment status is such that there is a moderately high positive correlation between members of a clinical team about pupils who are well and poorly adjusted in school. In order to interpret these tables in more detail, it must be remembered that in order to be significant at the 5% level an r of .288 is needed for fifth grade girls, .200 for fifth grade boys and .225 for both second grade girls and boys.

J. Selection of a Criterion Measure

Twenty-five qualitative judgments were made on each pupil seen by the clinical teams. These judgments were focused on assessments of genetic or physical factors, aspects of the child's social environment and measures of each pupil on general aspects of personality which the clinicians thought they could evaluate at the conclusion of their interview. No attempt was made to develop a priority procedure for weighting any of these qualitative judgments, nor to equate the number of judgments made in each particular group. In some cases more than one judgment was made on a trait such as mental ability since the clinicians felt that different aspects of the trait could be evaluated. Each qualitative judgment covered a five-point spread, had a mean value around a rating of "3" and was distributed over the five-point range of possible ratings. More than half of these judgments were significantly correlated with the original teacher rating of school adjustment on which the sample of pupils was selected. Table XI which was presented previously contains all of the correlations between these qualita tive judgments and the original teacher rating. Tables XII through XVII contain all of the intercorrelations of the qualitative judgments. What clues do we have at this point for selecting either one or more of these qualitative judgments, or one of the over-all judgments for a criterion measure?

The criterion problem for this study is to locate by means of clinical appraisal pupils with good and poor school adjustment. In addition, in order to have a class of measurement which would be adequate for use in multiple prediction equations, more than a dichotomized criterion is necessary. Whatever criterion is selected, it should have somewhat equal value for each of the samples in terms of relationship to other criteria of school adjustment. Table XI indicates that the individual qualitative judgments do not have uniform enough correlations with original teacher rating of school adjustment to be considered as single criterion measures. The sum of all of the qualitative judgments as well as the sum of the three final clinical judgments of school adjustment status appear to be the two best measures so far as correlating with original teacher appraisal of adjustment status is concerned. A check of the means

TABLE XII

Intercorrelation of Psychologists' and Social Workers' Qualitative Judgments
Second Grade Boys and Girls

	Psychologist													Social Worker								
PSYCHOLOGICAL JUDGMENTS	1	2	3	4	5	6	7	8	9	10	11	12	13	1	2	3	4	5	6	7	8	9
1. Poor Intell. functioning		.45	.37	.59	.79	.62	.55	.83	.95	.30	.48	.79	.57	.19	.19	.28	.25	.19	.27	.31	.30	.45
2. Severe perceptual difficulties	.51		.50	.62	.59	.58	.61	.58	.48	.83	.55	.77	.64	.26	.37	.19	.34	.21	.36	.28	.36	.50
3. Severe personality disturbances	.19	.39		.51	.45	.63	.63	.42	.38	.46	.86	.72	.61	.07	.17	.16	.21	.08	.10	.15	.18	.34
4. Problems relating to classroom teacher	.42	.53	.47		.66	.66	.87	.73	.57	.50	.65	.84	.81	.24	.36	.26	.37	.25	.26	.23	.36	.47
5. Meets learning tasks effectively	.73	.60	.38	.64		.66	.71	.89	.82	.42	.52	.86	.66	.12	.19	.24	.25	.15	.21	.29	.26	.41
6. Has creative potential	.44	.47	.58	.54	.53		.66	.66	.59	.47	.75	.83	.65	.22	.19	.19	.24	.09	.13	.15	.22	.32
7. Has poor school adjustment	.47	.51	.54	.83	.62	.56		.70	.57	.49	.70	.85	.85	.18	.40	.27	.38	.29	.27	.29	.38	.48
8. Has poor school achievement	.87	.52	.21	.50	.78	.50	.49		.85	.43	.52	.87	.67	.20	.23	.34	.29	.18	.22	.31	.31	.42
9. Over-all rating of WISC	.91	.47	.10	.39	.72	.43	.44	.83		.34	.45	.78	.60	.21	.21	.32	.33	.19	.28	.39	.34	.46
10. Over-all rating of Bender	.42	.86	.46	.54	.63	.45	.62	.46	.39		.49	.65	.49	.12	.31	.21	.29	.16	.25	.29	.29	.42
11. Over-all rating of Rorschach	.19	.35	.86	.49	.42	.63	.60	.21	.14	.47		.80	.68	.23	.27	.30	.29	.19	.22	.18	.30	.44
12. Sum of qualitative judgments	.76	.76	.61	.76	.87	.74	.80	.79	.72	.77	.63		.83	.24	.33	.32	.37	.23	.29	.33	.38	.54
13. Final rating of school adjustment	.61	.61	.54	.81	.75	.61	.88	.65	.59	.70	.55	.88		.17	.42	.32	.41	.26	.34	.34	.40	.54
SOCIAL WORKER JUDGMENTS																						
1. Serious physical problems	-.06	-.08	.04	-.04	.05	-.02	-.07	.02	-.03	.05	.11	.00	-.01		.45	.36	.48	.52	.50	.37	.66	.51
2. Deviant psychological development	.08	.17	.11	.17	.28	.01	.15	.17	.11	.27	.14	.21	.24	.51		.54	.73	.75	.73	.53	.84	.68
3. Poor social environment	.19	.16	-.13	.15	.23	.01	.06	.32	.23	.19	-.09	.17	.18	.21	.55		.68	.51	.60	.65	.77	.51
4. Family might produce a child with problems	.17	.26	.07	.15	.33	.06	.23	.24	.17	.32	.20	.27	.29	.23	.70	.59		.65	.65	.68	.86	.63
5. Serious personality problems	.05	.18	-.01	.16	.31	-.05	.15	.16	.09	.21	.10	.18	.21	.48	.80	.43	.67		.76	.59	.84	.60
6. School adjustment problems	.13	.28	.13	.19	.25	.08	.22	.16	.11	.33	.13	.25	.38	.25	.70	.47	.69	.68		.65	.86	.71
7. School learning problems	.40	.25	.05	.19	.40	.13	.17	.41	.33	.24	.08	.33	.37	.24	.53	.39	.56	.46	.72		.79	.64
8. Sum of qualitative judgments	.19	.23	.06	.18	.35	.05	.17	.28	.20	.31	.14	.27	.32	.55	.89	.67	.82	.84	.84	.74		.76
9. Final rating of school adjustment	.40	.45	.14	.37	.48	.26	.36	.43	.39	.44	.17	.48	.51	.22	.56	.54	.63	.56	.74	.67	.73	

TABLE XIII

Intercorrelations of Psychologists' and Social Workers' Qualitative Judgments
Fifth Grade Boys and Girls

	Psychologist													Social Worker								
	1	2	3	4	5	6	7	8	9	10	11	12	13	1	2	3	4	5	6	7	8	9
PSYCHOLOGICAL JUDGMENTS																						
1. Poor Intell. functioning		.51	.47	.55	.77	.62	.63	.89	.91	.38	.40	.85	.63	.11	.44	.40	.45	.36	.37	.42	.49	.46
2. Severe perceptual difficulties	.40		.39	.49	.51	.36	.56	.52	.44	.69	.48	.71	.65	.14	.34	.32	.37	.33	.17	.22	.36	.38
3. Severe personality disturbances	.30	.52		.55	.48	.47	.63	.52	.48	.36	.88	.72	.64	.03	.20	.17	.12	.22	.14	.30	.22	.41
4. Problems relating to classroom teacher	.61	.47	.48		.63	.50	.85	.61	.51	.37	.58	.78	.69	.11	.23	.19	.20	.29	.09	.11	.22	.29
5. Meets learning tasks effectively	.79	.44	.41	.56		.60	.72	.81	.83	.29	.48	.85	.75	.11	.27	.33	.45	.29	.26	.29	.39	.46
6. Has creative potential	.55	.49	.50	.42	.47		.44	.56	.59	.22	.48	.67	.52	.10	.26	.20	.19	.23	.26	.26	.30	.36
7. Has poor school adjustment	.49	.39	.47	.73	.65	.22		.73	.64	.43	.64	.86	.74	.13	.32	.27	.30	.35	.12	.27	.32	.36
8. Has poor school achievement	.83	.49	.39	.60	.85	.48	.60		.89	.43	.46	.88	.69	.04	.41	.34	.44	.36	.27	.37	.43	.41
9. Over-all rating of WISC	.92	.41	.33	.58	.82	.53	.55	.85		.30	.45	.84	.63	.07	.33	.36	.42	.33	.32	.46	.45	.42
10. Over-all rating of Bender	.23	.69	.34	.32	.39	.24	.32	.33	.23		.31	.57	.41	.12	.39	.36	.41	.31	.17	.14	.36	.39
11. Over-all rating of Rorschach	.30	.55	.91	.50	.42	.55	.47	.42	.35	.42		.71	.66	.12	.16	.17	.06	.19	.06	.19	.17	.29
12. **Sum of qualitative judgments**	.79	.71	.69	.76	.83	.66	.73	.84	.81	.55	.72		.83	.14	.40	.38	.41	.39	.26	.36	.45	.50
13. Final rating of school adjustment	.52	.49	.50	.73	.64	.31	.81	.63	.54	.44	.51	.75		.03	.31	.34	.30	.32	.18	.36	.36	.49
SOCIAL WORKER JUDGMENTS																						
1. Serious physical problems	-.03	.07	-.02	.07	-.01	-.13	.08	.03	-.08	.16	.02	.03	.15		.27	.38	.26	.30	.14	.00	.45	.19
2. Deviant psychological development	.13	.06	-.04	.21	.18	.01	.19	.15	.10	.05	-.06	.11	.16	.32		.75	.70	.87	.70	.40	.89	.60
3. Poor social environment	.30	.08	.05	.22	.23	.10	.20	.25	.26	.09	-.03	.19	.20	.26	.52		.65	.71	.55	.39	.84	.56
4. Family might produce a child with problems	.14	.62	-.03	.16	.24	-.13	.30	.13	.14	.04	-.12	.13	.31	.35	.71	.51		.68	.63	.41	.82	.61
5. Serious personality problems	.08	.11	-.03	.16	.20	.01	.21	.13	.08	.19	-.02	.15	.23	.38	.81	.47	.74		.63	.50	.88	.61
6. School adjustment problems	.17	.18	.07	.21	.18	.01	.28	.21	.11	.10	.05	.20	.33	.43	.65	.44	.67	.68		.49	.77	.69
7. School learning problems	.35	.20	.12	.24	.43	.09	.29	.40	.34	.19	.13	.33	.24	.18	.49	.34	.29	.43	.30		.61	.51
8. Sum of qualitative judgments	.23	.15	.03	.25	.29	.00	.30	.26	.19	.17	.07	.23	.32	.54	.87	.67	.81	.88	.80	.60		.71
9. Final rating of school adjustment	.36	.33	.15	.35	.44	.27	.40	.44	.36	.28	.21	.45	.43	.31	.49	.33	.42	.58	.63	.59	.66	

TABLE XIV
Intercorrelation of Psychologists' and Psychiatrists' Qualitative Judgments
2nd Grade Boys and Girls

	Psychologist													Psychiatrist								
	1	2	3	4	5	6	7	8	9	10	11	12	13	1	2	3	4	5	6	7	8	9
PSYCHOLOGICAL JUDGMENTS																						
1. Poor intell. functioning		.45	.37	.59	.79	.62	.55	.83	.95	.30	.48	.79	.57	.38	.35	.50	.53	.32	.33	.44	.46	.62
2. Severe perceptual difficulties	.51		.50	.62	.59	.58	.61	.58	.48	.83	.55	.77	.64	.18	.17	.23	.16	.19	.15	.20	.21	.42
3. Severe personality disturbances	.19	.39		.51	.45	.63	.63	.42	.38	.46	.86	.72	.61	.19	.19	.21	.30	.28	.27	.36	.29	.45
4. Problems relating to classroom teacher	.42	.53	.47		.66	.66	.87	.73	.57	.50	.65	.84	.81	.34	.34	.24	.25	.29	.24	.30	.33	.53
5. Meets learning tasks effectively	.73	.60	.38	.64		.66	.71	.89	.82	.42	.52	.86	.66	.27	.21	.37	.36	.23	.22	.28	.31	.55
6. Has creative potential	.44	.47	.58	.54	.53		.66	.66	.59	.47	.75	.83	.65	.31	.27	.41	.36	.33	.29	.47	.39	.53
7. Has poor school adjustment	.47	.51	.54	.83	.62	.56		.70	.57	.49	.70	.85	.85	.35	.32	.26	.27	.33	.30	.31	.35	.56
8. Has poor school achievement	.87	.52	.21	.50	.78	.50	.49		.85	.43	.52	.87	.67	.24	.24	.37	.32	.20	.20	.27	.30	.57
9. Over-all rating of WISC	.91	.47	.10	.39	.72	.43	.44	.83		.34	.45	.78	.60	.35	.34	.49	.49	.31	.30	.43	.44	.61
10. Over-all rating of Bender	.42	.86	.46	.54	.63	.45	.62	.46	.39		.49	.65	.49	.08	.12	.21	.17	.15	.17	.18	.17	.34
11. Over-all rating of Rorschach	.19	.35	.86	.49	.42	.63	.60	.21	.14	.47		.80	.68	.25	.29	.29	.27	.30	.32	.34	.34	.53
12. Sum of qualitative judgments	.76	.76	.61	.76	.87	.74	.80	.79	.72	.77	.63		.83	.33	.32	.41	.39	.33	.32	.41	.41	.65
13. Final rating of school adjustment	.61	.61	.54	.81	.75	.61	.88	.65	.59	.70	.55	.88		.38	.38	.32	.28	.36	.33	.38	.40	.56
PSYCHIATRIC JUDGMENTS																						
1. Comfortable with himself	.06	.13	.02	.14	.22	-.02	.14	-.01	.05	.19	.08	.13	.19		.86	.64	.58	.89	.76	.70	.90	.79
2. Comfortable with others	.17	.20	-.01	.08	.30	.01	.10	.08	.19	.24	.04	.18	.18	.87		.73	.65	.80	.77	.74	.92	.74
3. Serious learning difficulties	.45	.19	.03	.23	.47	.18	.25	.39	.42	.25	.05	.35	.40	.61	.63		.70	.66	.62	.78	.83	.68
4. Serious behavior problems	.19	.20	/04	.31	.33	.03	.26	.16	.18	.19	.04	.23	.33	.48	.52	.66		.61	.66	.75	.81	.59
5. Child needs help	.26	.25	.07	.24	.43	.18	.22	.21	.27	.29	.09	.31	.33	.72	.70	.72	.66		.74	.70	.90	.74
6. Appropriate contact with reality	.02	.19	.04	.07	.18	-.01	.11	.01	.03	.26		.11	.19	.51	.59	.56	.57	.62		.72	.86	.64
7. Poor school adjustment	.31	.26	.01	.13	.40	.09	.19	.26	.30	.26	.02	.27	.30	.65	.67	.83	.70	.69	.68		.88	.66
8. Sum of qualitative judgments	.23	.23	.03	.19	.39	.07	.20	.18	.24	.27	.05	.25	.31	.83	.85	.85	.77	.88	.77	.89		.80
9. Final rating of school adjustment	.49	.46	.13	.38	.56	.21	.35	.49	.46	.43	.13	.51	.51	.62	.60	.70	.49	.52	.37	.63	.67	

TABLE XV

Intercorrelations of Psychologists' and Psychiatrists' Qualitative Judgments

5th Grade Boys and Girls

	Psychologist													Psychiatrist								
	1	2	3	4	5	6	7	8	9	10	11	12	13	1	2	3	4	5	6	7	8	9
PSYCHOLOGICAL JUDGMENTS																						
1. Poor intell. functioning		.51	.47	.55	.77	.62	.63	.89	.91	.38	.40	.85	.63	.07	-.01	.13	.02	-.07	-.10	.11	.02	.53
2. Severe perceptual difficulties	.40		.39	.49	.51	.36	.56	.52	.44	.69	.48	.71	.65	.08	.01	.19	.11	.03	-.08	.07	.07	.42
3. Severe personality disturbances	.30	.52		.55	.48	.47	.63	.52	.48	.36	.88	.72	.64	.08	-.02	.16	.21	.09	-.06	.02	.08	.43
4. Problems relating to classroom teacher	.61	.47	.48		.63	.50	.85	.61	.51	.37	.58	.78	.69	-.01	.02	.20	.03	.06	-.05	-.02	.04	.36
5. Meets learning tasks effectively	.79	.44	.41	.56		.60	.72	.81	.83	.29	.48	.85	.75	.11	.11	.19	.07	.04	-.05	.10	.09	.51
6. Has creative potential	.55	.49	.50	.42	.47		.44	.56	.59	.22	.48	.67	.52	.24	.27	.16	.13	.18	.08	.19	.21	.53
7. Has poor school adjustment	.49	.39	.47	.73	.65	.22		.73	.64	.43	.64	.86	.74	.03	-.04	.16	.02	.01	-.08	.04	.02	.45
8. Has poor school achievement	.83	.49	.39	.60	.85	.48	.60		.89	.43	.46	.88	.69	.09	.04	.15	.05	-.02	-.11	.04	.04	.45
9. Over-all rating of WISC	.92	.41	.33	.58	.82	.53	.55	.85		.30	.45	.84	.63	.09	.07	.09	.01	-.07	-.10	.11	.03	.59
10. Over-all rating of Bender	.23	.69	.34	.32	.39	.24	.32	.33	.23		.31	.57	.41	-.03	-.14	.13	.17	-.04	-.14	.03	-.01	.29
11. Over-all rating of Rorschach	.30	.55	.91	.50	.42	.55	.47	.42	.35	.42		.71	.66	.09	.04	.18	.21	.16	-.04	.05	.12	.49
12. Sum of Qualitative judgments	.79	.71	.69	.76	.83	.66	.73	.84	.81	.55	.72		.83	.09	.02	.20	.11	.03	-.10	.08	.07	.60
13. Final rating of school adjustment	.52	.49	.50	.73	.64	.31	.81	.63	.54	.44	.51	.75		.16	.07	.27	.17	.14	-.02	.09	.15	.40
PSYCHIATRIC JUDGMENTS																						
1. Comfortable with himself	.21	.05	.11	.10	.10	.10	.06	.19	.16	.03	.09	.15	.19		.73	.54	.61	.73	.57	.70	.84	.47
2. Comfortable with others	.13	.01	.01	.06	.07	.11	.02	.13	.10	.00	.05	.09	.14	.75		.56	.52	.68	.60	.67	.82	.45
3. Serious learning difficulties	.36	.20	.17	.15	.28	.31	.07	.30	.28	.17	.20	.32	.17	.58	.64		.73	.68	.66	.77	.84	.57
4. Serious behavior problems	.27	.05	.00	.09	.17	.16	-.04	.23	.20	-.01	.02	.15	.08	.41	.55	.62		.71	.43	.71	.80	.49
5. Child needs help	.13	.03	.14	.08	.04	.09	.00	.13	.07	-.03	.09	.10	.17	.80	.68	.57	.53		.64	.66	.88	.40
6. Appropriate contact with reality	.09	-.03	.05	.02	-.04	.10	-.11	.02	.05	-.09	.04	.01	.00	.58	.55	.55	.53	.57		.62	.78	.34
7. Poor school adjustment	.33	.22	.11	.18	.22	.29	.02	.27	.27	.18	.18	.29	.14	.55	.65	.84	.74	.59	.63		.87	.69
8. Sum of qualitative judgments	.26	.09	.11	.12	.15	.19	.01	.23	.20	.04	.12	.19	.17	.82	.84	.84	.75	.83	.77	.87		.58
9. Final rating of school adjustment	.38	.32	.31	.34	.37	.35	.28	.43	.35	.26	.37	.47	.32	.45	.54	.63	.51	.44	.39	.66	.64	

TABLE XVI

Intercorrelations of Psychiatrists' and Social Workers' Qualitative Judgments
Second Grade Boys and Girls

	Psychiatric Judgments									Social Worker Judgments								
PSYCHIATRIC JUDGMENTS	1	2	3	4	5	6	7	8	9	1	2	3	4	5	6	7	8	9
1. Comfortable with himself		.86	.64	.58	.89	.76	.70	.90	.79	.28	.37	.06	.27	.30	.25	.29	.32	.59
2. Comfortable with others	.87		.73	.65	.80	.77	.74	.92	.74	.30	.40	.15	.29	.35	.27	.31	.37	.61
3. Serious learning difficulties	.61	.63		.70	.66	.62	.78	.83	.68	.33	.25	.22	.29	.29	.25	.39	.36	.60
4. Serious behavior problems	.48	.52	.66		.61	.66	.75	.81	.59	.09	.16	.11	.14	.19	.14	.21	.19	.44
5. Child needs help	.72	.70	.72	.66		.74	.70	.90	.74	.20	.36	.06	.27	.31	.23	.31	.31	.55
6. Appropriate contact with reality	.51	.59	.56	.57	.62		.72	.86	.64	.28	.44	.27	.34	.39	.31	.29	.41	.67
7. Poor school adjustment	.65	.67	.83	.70	.69	.68		.88	.66	.17	.18	.10	.25	.21	.10	.22	.21	.46
8. Sum of qualitative judgments	.83	.85	.85	.77	.88	.77	.89		.80	.27	.36	.15	.30	.34	.26	.33	.36	.64
9. Final rating of school adjustment	.62	.60	.70	.49	.52	.37	.63	.67		.27	.40	.24	.40	.30	.27	.42	.41	.65
SOCIAL WORKER JUDGMENTS																		
1. Serious physical problems	.17	.11	.13	-.07	.07	.07	.06	.09	.10		.45	.36	.48	.52	.50	.37	.66	.51
2. Deviant psychological development	.23	.17	.37	.22	.22	.23	.36	.30	.49	.51		.54	.73	.75	.73	.53	.84	.68
3. Poor social environment	.13	.05	.29	.20	.21	.07	.20	.20	.44	.21	.55		.68	.51	.60	.65	.77	.51
4. Family might produce a child with problems	.14	.04	.23	.17	.19	.09	.23	.19	.43	.23	.70	.59		.65	.65	.68	.86	.63
5. Serious personality problems	.22	.14	.29	.23	.21	.15	.30	.26	.40	.48	.80	.43	.67		.76	.59	.84	.60
6. School adjustment problems	.28	.20	.35	.24	.26	.26	.31	.31	.47	.25	.70	.47	.69	.68		.65	.86	.71
7. School learning problems	.18	.12	.43	.14	.22	.19	.32	.26	.49	.24	.53	.39	.56	.46	.72		.79	.64
8. Sum of qualitative judgments	.26	.16	.34	.21	.27	.21	.34	.31	.53	.55	.89	.67	.82	.84	.84	.74		.76
9. Final rating of school adjustment	.36	.29	.54	.34	.37	.27	.45	.43	.69	.22	.56	.54	.63	.56	.74	.67	.73	

TABLE XVII

Intercorrelations of Psychiatrists' and Social Workers' Qualitative Judgments
Fifth Grade Boys and Girls

	Psychiatric Judgments									Social Worker Judgments								
	1	2	3	4	5	6	7	8	9	1	2	3	4	5	6	7	8	9
PSYCHIATRIC JUDGMENTS																		
1. Comfortable with himself		.73	.54	.61	.73	.57	.70	.84	.47	.21	.07	.16	.07	.16	.06	.29	.19	.28
2. Comfortable with others	.75		.56	.52	.68	.60	.67	.82	.45	.03	.00	.03	.04	.05	.13	.24	.10	.26
3. Serious learning difficulties	.58	.64		.73	.68	.66	.77	.84	.57	.15	.11	.07	.20	.11	.23	.19	.21	.53
4. Serious behavior problems	.41	.55	.62		.71	.43	.71	.80	.49	.16	.10	.23	.11	.11	.20	.14	.19	.44
5. Child needs help	.80	.68	.57	.53		.64	.66	.88	.40	.10	.01	.05	.05	.01	.05	.12	.08	.30
6. Appropriate contact with reality	.58	.55	.55	.53	.57		.62	.78	.34	.17	-.02	-.09	.05	-.01	.09	.08	.06	.40
7. Poor school adjustment	.55	.65	.84	.74	.59	.63		.87	.69	.21	.20	.27	.24	.20	.32	.29	.33	.49
8. Sum of qualitative judgments	.82	.84	.84	.75	.83	.77	.87		.58	.18	.07	.11	.12	.10	.17	.23	.19	.45
9. Final rating of school adjustment	.45	.54	.63	.51	.44	.39	.66	.64		.25	.33	.37	.39	.38	.45	.45	.49	.57
SOCIAL WORKER JUDGMENTS																		
1. Serious physical problems	.11	.15	.22	.10	.09	.09	.26	.18	.29		.27	.38	.26	.30	.14	.00	.45	.19
2. Deviant psychological development	.04	.01	.13	.01	.06	.07	.15	.10	.33	.32		.75	.70	.87	.70	.40	.89	.60
3. Poor social environment	.02	-.06	.18	.04	.07	.02	.09	.06	.19	.26	.52		.65	.71	.55	.39	.84	.56
4. Family might produce a child with problems	-.06	-.04	.01	-.01	-.01	-.07	.02	-.02	.21	.35	.71	.51		.68	.63	.41	.82	.61
5. Serious personality problems	.07	.05	.13	-.01	.08	.04	.15	.10	.33	.38	.81	.47	.74		.63	.50	.88	.61
6. School adjustment problems	.05	.01	.21	.13	.11	.05	.19	.14	.37	.43	.65	.44	.67	.68		.49	.77	.69
7. School learning problems	.18	.18	.43	.33	.25	.19	.48	.37	.49	.18	.49	.34	.29	.43	.30		.61	.51
8. Sum of qualitative judgments	.08	.06	.25	.11	.12	.07	.25	.18	.42	.54	.87	.67	.81	.88	.80	.60		.71
9. Final rating of school adjustment	.13	.21	.45	.24	.15	.24	.46	.34	.56	.31	.49	.33	.42	.58	.63	.59	.66	

and standard deviations of all of the individual qualitative judgments made by the social workers and psychiatrists and those made by the psychologists including the sum of all the qualitative judgments and the sum of the three final ratings of school adjustment can be found on Tables XVIII and XIX respectively. The means of the final ratings of school adjustment appear quite comparable; the means of the social worker and psychiatrist would differ necessarily from those of the psychologist when one compares the means for the sum of all the qualitative ratings because of the different number of ratings made by these groups.

Further evaluation of the sum of all qualitative judgments or the sum of the three final judgments as possible criteria can be made by comparing the degree to which correlations between clinical groups are in agreement. Tables XX and XXI contain the intercorrelations for each of these measures. For both second and fifth grade, and for both boys and girls, the highest intercorrelations exist between the sum of the qualitative judgments and the over-all judgment for each clinical group. In other words the degree to which high or low ratings were given on each of the qualitative judgments by a particular clinical group has a very high positive correlation with the final rating of school adjustment. Second in order of magnitude of correlations are those which compare the degree to which the final or over-all ratings of school adjustment were in agreement between clinical groups. Correlations ranging from a magnitude of .449 to .071 for those comparing the sum of qualitative judgments for each clinical group with an average correlation of .29 are not as substantial as those which indicate the degree of agreement between the final judgments of school adjustment status for the same pupils. The range of intercorrelations for the final judgments of school adjustment made by the clinical groups from .687 to .324 indicate considerable agreement among the clinical groups when it comes to making an over-all judgment of school adjustment status. The average of all these intercorrelations was .52 indicating tood, general agreement over all comparisons. Of interest is the fact that the highest correlation (.687) between final judgments was made by social workers and psychiatrists for second grade boys. The lowest correlation (.324) was found in the comparison of the judgments of school adjustment made by psychologists and psychiatrists for fifth grade boys.

Because of the regular shapes of the distributions of ratings assigned by each clinical group and the high intercorrelations between the ratings, the sum of the three over-all judgments of school adjustment status was selected as the criterion measure against which to evaluate the ratings in the screening process, individually and collectively.

The means and standard deviations for the selected criterion can be found on Table XIX. The range of this measure is from 3 to 15 or from three ratings of "1" for over-all school adjustment as judged by the clinical team to three ratings of "5". The average rating varies from 8 to 10 with standard deviations varying from 2 to 4.

Description of Groups of Pupils with Consensus Clinical Judgments of Good and Poor School Adjustment

The moderately high, positive correlations between final judgments of school adjustment status made by the clinicians suggest that some gain could be made by comparing selected data collected for those pupils judged to be relatively free from school problems with those judged to have considerable school adjustment difficulty. Accordingly, pupils with a "1" or "2" on all three final judgments of school adjustment status made by the clinical team were sorted out and designated the group of pupils with consensus clinical judgment of "well adjusted." Using a similar procedure, pupils with either a "4" or "5" on all three final judgments made by the clinical team were sorted out as a group with consensus clinical judgment of poor school adjustment.

TABLE XVIII

Means and Standard Deviations For All Social Worker and Psychiatrist Qualitative Judgments

	2nd Grade Girls		2nd Grade Boys		Fifth Grade Girls		Fifth Gr Boys	
SOCIAL WORKER JUDGMENTS	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.
1. This child has serious physical problems	2.59	1.21	2.88	1.19	2.60	1.07	2.78	1.
2. The development shows deviant psychological patterns	2.45	1.25	2.82	1.22	2.35	1.21	2.99	1.
3. Social environment conducive to poor school adjustment	2.53	1.17	3.00	1.08	2.51	1.17	2.71	1.1
4. Family might produce a child with problems	2.76	1.25	3.16	1.03	2.56	1.28	3.01	1.1
5. Serious personality problems	2.60	.99	2.94	1.17	2.24	1.08	2.93	1.1
6. School adjustment problems	2.37	.98	2.91	1.12	1.95	.92	2.71	1.0
7. School learning problems	2.49	1.12	2.99	1.27	2.49	1.11	2.93	1.1
8. Sum of Social Worker Qualitative judgments	17.73	6.40	20.67	6.18	16.76	6.09	20.07	5.9
9. Final Social Worker judgment of school adjustment	2.65	1.15	3.08	1.02	2.43	1.04	3.08	1.1
10. Troubled or troublesome child	.88	.82	1.17	.84	.96	.76	1.19	.8
PSYCHIATRIST QUALITATIVE JUDGMENTS								
1. Is child comfortable with himself	2.94	1.29	2.90	1.24	3.11	1.13	3.21	1.20
2. Is child comfortable with others	2.82	1.17	2.99	1.30	2.95	1.08	3.23	1.11
3. Has serious learning difficulties	2.59	.99	2.86	1.21	2.84	1.05	2.97	1.15
4. Has serious behavior problems	2.40	1.06	2.64	1.17	2.48	1.03	2.81	1.02
5. Child needs help	2.93	1.19	3.15	1.19	2.98	1.20	3.38	1.19
6. Has appropriate contact with and relationship to reality	2.32	1.06	2.59	1.11	2.46	1.19	2.72	1.21
7. Generally poor school adjustment	2.40	1.02	2.79	1.23	2.57	.96	2.89	1.14
8. Sum of psychiatrist qualitative judgments	18.41	6.79	19.86	6.98	19.37	6.35	21.16	6.49
9. Final psychiatrist judgment of school adjustment	2.91	1.05	3.14	1.13	2.77	.93	3.21	1.09
10. Troubled or troublesome child	.79	.84	1.16	.86	1.23	.80	1.27	.76

TABLE XIX

Means and Standard Deviations of All Psychologist Qualitative Judgments, Sum of All Qualitative Clinical Judgments And Sum of Final Judgment of School Adjustment Status

PSYCHOLOGISTS JUDGMENTS	2nd Grade Girls		2nd Grade Boys		Fifth Grade Girls		Fifth Grade Boys	
	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.
1. Poor intellectual functioning	3.03	1.16	2.77	1.25	2.95	1.25	2.84	1.16
2. Severe perceptual difficulties	2.97	1.15	2.08	1.21	2.86	1.20	3.04	1.13
3. Severe personality disturbances	3.04	1.25	3.27	1.09	3.00	.98	3.26	1.17
4. Problems relating to classroom teacher	3.11	1.19	3.05	1.11	2.73	1.09	3.15	1.12
5. Meets learning tasks effectively	3.20	1.25	3.04	1.29	3.00	1.17	2.95	1.16
6. Has creative potential	3.01	1.15	3.08	1.18	2.91	.97	2.77	1.22
7. Has poor school adjustment	3.15	1.17	3.03	1.12	2.80	1.09	3.22	1.16
8. Has poor school achievement	3.11	1.20	2.92	1.23	3.00	1.25	2.98	1.26
9. Over-all rating of WISC	3.08	1.12	2.77	1.20	3.00	1.18	2.86	1.23
10. Over-all rating of Bender	3.05	1.20	3.15	1.18	2.84	1.27	3.15	1.20
11. Over-all rating of Rorschach	3.09	1.25	3.34	1.10	3.07	1.01	3.11	1.24
12. Sum of psychologist qualitative judgments	33.88	10.48	33.48	9.72	32.16	9.60	33.43	9.82
13. Final psychologist judgment of school adjustment	3.05	1.20	3.09	1.11	2.89	1.08	3.25	1.06
14. Troubled or troublesome child	.72	.91	.89	.95	.63	.88	.87	.95
Sum of all Qualitative Judgments	69.76	18.29	73.44	16.72	68.09	15.78	75.17	15.93
Sum of Final Clinical Judgments of School Adjustment	8.58	2.92	9.26	2.81	8.05	2.46	9.42	2.61

TABLE XX

Intercorrelations of Sum of Qualitative Ratings And Final Rating of School Adjustment Made By Each Clinical Group - Second Grade*

	1	2	3	4	5	6
1. Sum of Social Worker Qualitative Judgments		.272	.308	.732	.319	.530
2. Sum of Psychologists' Qualitative Judgments	.376		.255	.480	.884	.510
3. Sum of Psychiatrists' Qualitative Judgments	.357	.408		.434	.314	.666
4. Over-all Judgment of School Adjustment by Social Worker	.762	.480	.434		.511	.687
5. Over-all Judgment of School Adjustment by Psychologist	.401	.827	.314	.542		.506
6. Over-all Judgment of School Adjustment by Psychiatrist	.406	.650	.796	.649	.561	

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*Correlations for the sample of boys are above the diagonal; those for girls are below.

TABLE XXI

Intercorrelations of Sum of Qualitative Ratings And Final Rating of School Adjustment Made By Each Clinical Group - Fifth Grade*

	1	2	3	4	5	6
1. Sum of Social Worker Qualitative Judgments		.234	.178	.659	.321	.420
2. Sum of Psychologists' Qualitative Judgments	.449		.195	.445	.751	.473
3. Sum of Psychiatrists' Qualitative Judgments	.191	.071		.343	.166	.636
4. Over-all Judgment of School Adjustment by Social Worker	.711	.496	.455		.430	.559
5. Over-all Judgment of School Adjustment by Psychologist	.358	.828	.149	.490		.324
6. Over-all Judgment of School Adjustment by Psychiatrist	.495	.595	.577	.574	.404	

*Correlations for the Sample of Boys are above the diagonal; those for girls are below.

The distribution of these pupils by grade and sex is as follows:

Clinical group	Project Sample			
	2nd grade girls	2nd grade boys	fifth grade girls	fifth grade boys
1. Consensus well adjusted	13	9	11	5
2. Neither well nor poorly adjusted	45	45	38	65
3. Consensus poorly adjusted	7	13	3	18
Total	75	73	55	95

The above distributior indicates that three second grade boys to every two second grade girls were judged by the clinical team to have school adjustment problems. Such a breakdown is contrary to the typical estimate of the ratio of boys and girls with emotional handicaps as four to one, or three to one. This ratio does not hold for the fifth grade sample. At the fifth grade the rate of boys to girls with extreme problems noted by the clincians is in a ratio of six to one and therefore in agreement with quotations from other research workers. This is not the entire picture, however. Since the final ratings were made by grade only, not separately by sex within the grade, many more girls can no doubt be located with school difficulties when one takes into consideration the sum of the three final judgments of school adjustment status and uses deviations from the mean of the sample as a cut-off point, instead of selecting only those with final ratings of "4" or "5". However, as a means of describing groups of pupils for whom clinicians were in agreement as to the presence or absence of school difficulties, this procedure of describing children with consensus clinical judgment should provide good leads for further study. One should keep in mind that the differences between these groups might be altered if samples were selected on the basis of deviations from the mean by the sum of final clinical judgments. The method used here to describe criterion groups of pupils with consensus clinical judgment has the advantage of keeping constant the clinical perception of degree of school problems.

Tables with the distributions for each of the descriptive categories which are summarized below can be found in the Appendix. Significances of the differences were not computed. The summary statements for the selected distributions serve to provide a qualitative statement about the groups and not necessarily a probability statement about the presence of absence of any of the characteristics.

1. Comparison of the Samples of Second and Fifth Grade Pupils with Good and Poor School Adjustment Status on the Basis of Selected Pupil Data.

   The reports from the psychiatrist provide the only first-hand observational data on the samples which were collected under fairly controlled circumstances. Some of the findings of the psychiatrists can be compared later with teacher judgments, but for the purpose of this section of the report, these observations are useful in determining the degree to which the pupils are comparable at the extremes of the distribution of clinically judged school adjustment status.

   a. Psychiatrists' observations of pupil characteristics

      Whether the general appearance of the pupil was appropriate for the school situation or not was noted during the interview. The rating job was to note only whether the child's grooming and dress were appropriate or inappropriate. Table 1 presents these distributions which indicate that no general trend was found in any of the samples. About ten percent of each sample was noted to have unusual or inappropriate grooming and dress, but this fact seems not to be related to consensus clinical judgment of school adjustment.

Approximately 30 percent of the pupils seen by the psychiatrists were noted to have unusual physical characteristics such as deformities, acne, dental abnormalities, amputations or facial defects or disfigurements. Both second grade girls and fifth grade boys in the poorly adjusted samples were noted to have greater frequency of unusual physical characteristics. Table 2 lists the distributions for all of the samples.

From 60 to 70 percent of the samples were found to be neither overly passive nor overly hyperactive during the psychiatric interview. Table 3 indicates that boys were more often noted to be hyperactive with girls manifesting passive behavior more frequently. For second grade girls and boys, and fifth grade boys the consensus poorly adjusted group have greater frequencies of pupils judged to be either physically hyperactive or physically passive during the interview. Since the number of fifth grade girls judged to be poorly adjusted is so small (with three final ratings of "4" or "5") it is difficult to generalize about this sample. Nevertheless one-third of the equivocal group of fifth grade girls was judged to be physically passive during the interview suggesting that girls who are seen as more poorly adjusted tend to be more passive during psychiatric interviews.

The degree to which second or fifth grade pupils' speech is judged to be advanced, average or retarded can be noted on Table 4. The trend indicated in this table is for pupils judged to be poorly adjusted in school to have greater frequencies of retarded speech than their peers who are judged to be well adjusted.

Level of maturity translated into a judgment of "grown-up" or childish behavior is another interesting comparison for these samples of pupils interviewed by the psychiatrists. "Grown-up behavior appears to be more typical of pupils judged to be well-adjusted, while childish or immature behavior was found more typically in the poorly adjusted group as well as with those pupils with equivocal clinical judgments of school adjustment status. While the conclusions from Table 5 are not too illuminating, the distributions are useful to the extent that they throw light on the frequencies of this type of rating in the samples under study.

The extent to which psychiatrists saw children at each grade level as overly conforming (obedient) or acting out (rebellious) can be found in Table 6. When the frequencies for the overly obedient and the rebellious categories are combined, there is a strong trend for children judged to be overly conforming or negativistic to be judged by the clinical teams as those with poor school adjustment.

How the pupil responds to the psychiatrist during the interview would seem to be a good item on which to compare pupils with good and poor school adjustment. Table 7 provides the data on the frequencies of pupil reaction to psychiatrists varying from strongly positive to strongly negative. By combining the equivocal and consensus poorly adjusted groups of pupils at all grade levels, with only two exceptions, the combined group contains the pupils who responded negatively to the psychiatrist during the interview. Responding positively to the psychiatrist cannot be taken as an indication that a pupil is without school difficulties, and no psychiatrist would use this as a single indication; however, a suggested inference might be that fear of a new situation, insecurity about one's role talking with a doctor, or general anxiety about the entire setting, all combine into a perception of the psychiatrist and other clinicians which results in a clinical inference of poor school adjustment.

Out of 293 pupils with complete clinical data, only ten aroused a negative reaction on the part of the psychiatrist. Table 8 indicates that most pupils were perceived positively by the psychiatrist, with varying numbers seen as positive or neutral depending on the sample. There appears to be some trend for pupils who were judged to be well adjusted to receive more positive reactions from psychiatrists, but this trend is not affirmed in all of the samples.

As noted previously in the report, the number of symptoms manifested by the child appears to be related to mental health problems. The psychiatrists tallied all of the symptoms which they noted during the interview on their interview form. The frequencies of the individual symptoms did not yield useful comparisons; therefore the total number of symptoms which were noted during the interview such as tics, nail-biting, speech disorders, posture, mannerisms, fearfulness, awkwardness, hyperactivity, impaired attention, etc., was determined for each pupil and then distributed according to consensus judgments of school adjustment status. The results can be found on Table 9. Between sixty and seventy percent of the pupils seen by the psychiatrists were noted to have none or only one symptom during the interview. The largest number of symptoms noted was in the case of a fifth grade boy where nine different symptoms were noted by the psychiatrist. Second grade girls and fifth grade boys judged to be poorly adjusted in school were those with noticeable differences in numbers of symptoms noted. Some second grade boys judged to be well-adjusted had a number of symptoms noted by the psychiatrist, and many in the equivocal group of second grade boys had more than one symptom. The picture for fifth grade girls is in the reverse since it appears that girls with more symptoms were judged to be better adjusted on the whole.

Most of the psychiatrists, and rightly so, were somewhat uncertain of their ability to arrive at a useful statement of the pupil's behavior during the one-hour interview. Accordingly an item on the interview schedule was included which provided a check on the confidence the psychiatrist held in the data which were collected. Table 10 indicates the distributions of these psychiatric self appraisals. The rank of frequencies is from fairly accurate, probably accurate, very accurate to grossly inaccurate for all samples. It is interesting to note that out of 44 cases where the psychiatrist felt that the data were very accurate, only two of these cases were in the poorly adjusted category.

b. Psychiatrists' observations of pupil characteristics compared with original teacher rating of school adjustment.

Eight tables are included in the Appendix which provide a cross-check on pupil characteristics noted by psychiatrists which should provide a useful check on the kind of pupils teachers originally selected as ones with good and poor school adjustment. Neither the teachers nor the psychiatrists found that unusual or inappropriate dress or grooming were related to school adjustment status. Table 11 provides the distributions of appropriateness and inappropriateness of appearance in terms of original teacher rating of school adjustment.

While some relationship was noted between unusual physical characteristics and clinical judgment of poor school adjustment, no relationship was found between physical characteristics noted by psychiatrists and teacher's rating of school adjustment status. Table 12 indicates that even though twenty percent of the population had some unusual physical characteristic, teacher ratings of good school adjustment are just as common within the group with unusual physical characteristics as ratings of poor school adjustment.

When hyperactivity and passivity are compared to teacher ratings no relationship appears to show itself for the second grade sample. If teachers respond to such behavior they evidently do not relate it to school adjustment problems. They may see such differences as normal developmental changes. The fifth grade sample of girls judged to have poor school adjustment by teachers are more frequently noted to be physically passive by the psychiatrists. On the other hand, fifth grade boys judged to be hyperactive by the psychiatrists are more often judged by teachers to have poor school adjustment. Table 13 and Table 3 should be compared for possible differences between the characteristics of boys and girls with hyperactive and passive behavior at the fifth grade level judged to have poor school adjustment by teachers and clinicians.

Table 14 indicates that second grade girls whom the psychiatrist judged to be excessively grown-up for their age were more often given ratings indicating good school adjustment by the teacher. The reverse is true for second grade boys where those judged to be grown-up were more frequently rated as ones with poor adjustment by their teachers. In the case of childish or immature behavior, three of the four girls with excessively childish behavior as judged by the psychiatrists were given above average ratings of school adjustment by their teachers, while nearly all of the boys with childish behavior were rated as poorly adjusted. Evidently excessively "grown-up" and childish behavior in second grade boys is related to teachers' judgment of poor school adjustment but not so in second grade girls. There seems to be no relationship between these characteristics and teachers' rating for fifth grade girls; however all fifth grade boys judged to be childish by the psychiatrist were rated by teachers as having average or poorer school adjustment.

When psychiatrists' judgment of overly obedient or rebellious behavior is compared with teacher rating, there appears to be no general trend on which to comment. The overly obedient pupils appear to have generally lower ratings of school adjustment status, while the pupils judged to have moderate or extreme rebellion may have just about any rating of school adjustment. Further comparisons can be made by the reader by referring to Table 15.

Obviously a pupil will respond quite differently during a psychiatric interview when what is expected of him is not spelled out, than he will in a classroom where behavior standards are defined regularly by the teacher. Nevertheless, what relationship, if any, can be found between the child's reaction to the psychiatrist and teacher rating of school adjustment? Table 16 provides some hints even though the inferences are ambiguous at best. In the case of both second and fifth grade girls, those who were judged to have slightly or strongly negative reactions to the psychiatrist were most often seen by the teachers as ones with good school adjustment. Does this mean that girls do better in highly structured school situations, (therefore are seen by teachers as well adjusted) but become anxious or fearful when the limits of the interpersonal setting are less well-defined? While no trend shows up in the case of second grade boys, those fifth grade boys who were noted to have slightly to strongly negative reactions to the psychiatrist were most often noted by the teachers with average or poorer school adjustment.

What inferences should one draw from this when boys are typically described as having difficulty in conforming to the structure of the classroom? Do they also have difficulty in adjusting to the minimal structure set by the psychiatrist?

Table 17 indicates that whether the psychiatrist responds positively or negatively to the child has no relationship to teacher rating of school adjustment.

Table 18 provides the distribution of the total number of symptoms noted by psychiatrist compared with original teacher rating of school adjustment. From these data one is certain to note that no trend appears which relates noticeable symptoms to teacher rating of school adjustment. Assuming that the child manifests the same symptoms in the classroom that the psychiatrist noted during the interview, Table 18 raises questions as to whether teachers use presence or absence of symptoms in making a rating of school adjustment. Indeed, one must question the degree to which teachers are alert to symptoms as being indicative of adjustment difficulties.

c. Relationship of individual intelligence test results to consensus clinical judgment of school adjustment.

The psychologists who interviewed all of the pupils in the project sample administered a WISC to each child. The short form of the test contained five sub-tests, three Verbal and two Performance, from which the estimated Verbal and Performance IQs were computed by prorating the scaled scores on the sub-tests.

Table 19 illustrates the fact that there is a marked trend for pupils judged to be poorly adjusted by the clinicians to have low Verbal IQs. The relationship between IQ and other measures of school adjustment is described elsewhere. This table indicates that while the range of Verbal IQ scores is greater for poorly adjusted boys when compared to that for poorly adjusted girls, the average IQs are noticeably lower. A striking fact is that the three fifth grade girls judged to be poorly adjusted all had Verbal IQ scores at 75 or below. Evidently there is a high degree of relationship between clinical judgment of school adjustment status and Verbal IQ in the case of girls at the fifth grade level as well as in the other samples.

There is greater variability in the Performance IQ of the poorly adjusted group as indicated in Table 20; however, the trend continues for pupils judged to be poorly adjusted by clinicians to have lower Performance IQs.

By subtracting the estimated Performance IQ from the estimated Verbal IQ the relationship between these two estimates of intelligence for the samples can be determined. A minus sign indicates that the Performance IQ is greater than the Verbal and a plus sign indicates the reverse. Approximately half of each of the second and fifth grade samples can be found in the column which indicates that no more than a ten-point difference separated the Verbal and Performance IQ scores. No generalization can be made about the differences between the discrepancies and consensus clinical judgment, but it is obvious that differences in excess of ten points between the two sections of the test appear to turn up most often in favor of Performance IQ scores. (Table 21)

Table 22 provides the distribution of the estimated Full Scale WISC IQs. These data only repeat the statements made about the Verbal and Performance IQ scores. Poorly adjusted pupils as judged by clinicians tend to have lower IQs. This is what one would expect, except that in this report, the only clinician who knew the IQ score was the psychologist. One would guess that his judgments of school adjustment status might be contaminated with performance on the WISC, but neither the social worker nor the psychiatrist had any knowledge of the pupil's intelligence status. Therefore, one must infer that whatever the behavior is that is manifest in a pupil's doing well on the WISC is responded to by clinicians as being indicative of good school adjustment.

d. Relationship between consensus clinician judgment and pupils' achievement status in school.

In order to obtain an indication of the extent of accelerations and retentions in the project sample, the age of each pupil during the month of May, 1962 was found. This was compared with the average age of pupils as computed from school reports in the school districts where the project was conducted. From these data the degree to which a pupil was over-or under-age for his grade was found by subtracting the average age of pupils in his grade from his chronological age. The average ages of pupils in the schools where the project was conducted were as follows:

Grade	Average Age
B2	88 months
A2	94 months
B3	100 months
Second grade	98 months
B5	125 months
A5	131 months
B6	136 months
Fifth grade	134 months

Letters in front of the grade designation indicate mid-semester promotion, which permits a child to enter second grade either in September or February. When schools did not have mid-semester promotions, the average ages for second and fifth grade were used.

Table 23 presents the distributions of age-grade relationship for each of the samples. No generalizations can be made from these data about well and poorly adjusted pupils. The fact that a greater proportion of pupils are six months younger than the average age for the grade when one would expect an equivalent number on each side of the average age, indicates more frequent entry in school before the qualification age, more acceleration in general, or the fact that the average ages for each grade will need to be adjusted in the future for each of the school districts. With the exception of one fifth grade boy, who was 18 months older than the average pupil in his grade, no statements can be made about the number of retentions or accelerations for these samples. If students have been retained or accelerated, they have moved only one-half to one grade at the most above or below their regular assignment.

Tables 24 and 25 illustrate the achievement status in both reading and arithmetic for the project pupils. Since most schools used achievement tests with grade placement norms, a method for equating results of different tests given at different times was needed. The most recent reading and arithmetic achievement test score in grade placement units was taken from the cumulative record. Then the year and month of the grade in which the test was given was also recorded. By subtracting the actual grade placement of the pupil at the time he took the test from his test score, differences between his performance and grade expectancy can be found. The standard error of the achievement tests which were used (California Achievement Test, Metropolitan Achievement Tests and Stanford Achievement Tests) is about .5 grade placements. Thus any score which deviated only ½ of a school grade in either direction should be considered at grade level. Table 24 indicates that almost all second grade pupils are reading at grade level (possibly because test score ranges are small at this grade level) while about 60 per-cent of fifth grade pupils are reading at grade level (test score ranges at this level are greater providing more chances to achieve not only higher than grade, but lower than grade level scores). Where pupils were reading below grade level, they were most frequently in the poorly adjusted categories as judged by the clinicians. The situation with the arithmetic tests is a little different since so few pupils had below grade level scores. This is usually interpreted as a result of the fact that the arithmetic curriculum is locked into grade placement while the reading program at the elementary schools provides opportunities for pupils to move along at their own rate of progress. Nevertheless, when pupils were found to achieve below grade in arithmetic, they were not in the group judged to be well adjusted by the clinicians. The only poorly adjusted pupils who exceeded grade level standards in arithmetic were the boys at the fifth grade level.

Tables 26, 27, 28 and 29 present the results of the mid-year report card for all project pupils. This reporting period came toward the end of January 1962, just at the mid-point of the data collection for the project in the schools. In order for the grades to be comparable for all of the samples, only these mid-year grades were used. The range of grades for both reading and arithmetic is broader than those for language and social studies. In any case, the higher grades were awarded to the group the clinicians judged to be well-adjusted in school and the lower ones to the pupils they judged to be poorly adjusted. These findings are quite significant since they, along with the results of the WISC IQ scores indicate that clinicians are evidently responding to pupil characteristics which are related to intelligence and school achievement even though they have no knowledge of any of this information, and, in spite of the fact that the clinical teams hoped to hold intellectual status constant in their appraisal of pupil problems.

The number of unsatisfactory marks given in the citizenship section of the report card was also tallied. Table 30 shows that girls receive fewer unsatisfactory marks than boys, but that in any case pupils with poor school adjustment are the ones who more frequently tend to get low marks on citizenship. Cooperation, obedience, effort, dependability, health, thrift and others are the types of behavior that the teacher evaluates under "citizenship." Usually three marks are given: satisfactory, unsatisfactory and outstanding. For purpose of the description of pupils in this report only the distribution of unsatisfactory marks is recorded.

e. Information from the health card related to consensus clinical judgments of school adjustment status.

Height, weight, and health referrals for every pupil in the study were routinely recorded. The number of health referrals is reported elsewhere. Height and weight data were found to be difficult to interpret since the age of the pupil was not always recorded on the form, making it impossible to compare height and weight with age norms. The health card indicated, in addition, the number of absences during the first semester of the 1961-1962 school year, the number of tardies, and whether any vision or hearing defect had been noted.

The frequencies of absences for the project samples can be found on Table 31. While it is quite common for a pupil to have five or less absences in a 100-day semester, some pupils, approximately half of each sample, are absent from 5 days to 32 days during this period. Some differences in the poorly-adjusted and the equivocal groups can be noted on Table 31 since the excessive absences fall in these categories. The consensus well-adjusted group was found to have frequent absences, but a slightly greater proportion of this sample was in the absence frequency category of 0-5.

Twenty-six pupils out of 293 were tardy one or more times during the fall 1961 semester. Only one of the 26 was in the consensus well-adjusted group and three in the poorly-adjusted category. The remainder were in the equivocal group indicating that while the number of tardies cannot be linked for certain with school adjustment status, some relationship is probable. (Table 32)

Fifteen percent of the entire project sample was noted as having some vision defect and four percent had records of hearing difficulty. As one can readily see from Tables 33 and 34, no relationship between vision and hearing difficulties and school adjustment status can be determined from these data.

f. Birth Order and number of sibs compared with consensus clinical judgment

Even though birth order and number of siblings have been studied as important variables in school mental health status, the data collected on the project pupils fail to show any relationship. Tables 35 and 36 in the Appendix can be reviewed for the frequency for each sample of first born, second born, etc., but generalizations are difficult to make. No trend appears either for number of sibs in a family to be related to school adjustment. Since only ten to fifteen percent of the pupils who were studied fall into the "only child" category, one might find it fruitful to determine the school adjustment status of the sibs of the remainder of those pupils in the poorly-adjusted group. It seems to be a legitimate assumption that school problems would be more related to family characteristics than to the birth status of a particular child.

2. Comparison of the Samples of Second and Fifth Grade Pupils with Good and Poor Adjustment on the Basis of Developmental History and Home Conditions

a. Marital Status, Occupation of Father and Mother and Evidence of Ethnic Differences

Eight percent of the entire sample of pupils lived with a single parent. This means that the families of the great majority of pupils in the schools where this project was conducted were intact so far as the marital status of parents is concerned. Sometimes pupils had step-parents and rarely (only eight cases) had they been adopted, but in all the cases listed under the category "married," a mother and father were in the home. (Table 37)

When the occupation of the father was available from the cumulative folder, it was translated into code numbers from the Dictionary of Occupational Titles (37). From the distribution of the classification number, the level of occupation was determined and next distributed according to consensus clinical judgment. Table 38 indicates that while there is a somewhat ambiguous relationship, pupils judged to be poorly adjusted by the clinical teams had fathers who were more frequently found to work in the service, skilled, semi-skilled and unskilled laboring categories. Thus occupational status of parents can be expected to be importantly related to school adjustment and, along with intelligence and achievement, to be predictive of whether or not a clinician will judge the pupil to have school difficulties. This finding is equivalent to that from research quoted previously. Its importance lies perhaps more in the fact that clinicians are evidently utilizing behavior characteristics which are tied in with socio-economic status even though they are not consciously rating such characteristics when they interview the child.

From eight to 19 percent of the mothers of the project pupils were working at some employment outside the home. There appears to be no relationship between having a mother at work and whether or not a pupil falls into a clinically determined category of good and poor school adjustment. One must look beyond the simple fact of a "working mother" before inferences can be made about the effect of this upon a child. Just as in the case of children living with a single parent, the pupil personnel or clinical worker must determine whether this is in itself detrimental to the child, not just the fact that it exists. Table 39 provides the frequencies of working mothers for each of the samples.

If ethnic differences are at work in determining school adjustment status, some technique of gathering data other than noting the presence or absence of a foreign language in the home is necessary. Often the school is not aware that the parents converse regularly in a language other than English. In California Spanish speaking families, or families from Mexico, are quite common throughout the State. Some of these families have been in California longer than their non-Spanish neighbors; therefore one cannot generalize from the origin of a child's surname about the presence of cultural factors which might influence school status. One cannot say anything about ethnic differences per se from data which are ordinarily available on school records. If ethnic and national populations are found to be more vulnerable to school difficulties, better techniques for determining this relationship and recording it should be developed. About ten percent of the children in the project came from families where a foreign language was spoken in the home; however, no apparent relationship between this and school adjustment status appears to exist. (Table 40)

b. Evidence of genetic and physical factors related to school adjustment as determined from social worker home interview

Congenital defects and hereditary factors such as mental retardation, epilepsy, diabetes, etc., were noted by the social worker during the home interview with the parent. The social worker had to make note of whether any such factor were present and then determine whether this could be related to school adjustment status. Table 41 contains the distribution of genetic factors for each sample. Under the category "positive" are noted any factors which might have had a positive relationship to school adjustment; under negative, those factors which could have had a detrimental effect. When negative factors were noted, they most often fell in the poorly-adjusted or equivocal groups indicating a relationship between genetic conditions as noted in the developmental history and subsequent clinical judgment of school adjustment status.

The category "physical defects," next judged by the social workers was noted when any evidence, positive or negative, in the health history of previous or current illnesses, sensory organ defects, accidents, etc., was found. When negative factors were found in Table 42 they were more frequently related to poor school adjustment, even though some pupils judged to be well-adjusted also had some problems in this area.

Genetic factors, congenital defects and physical factors did not cover the range of information in the general health area which the social workers gathered. Allergies, enuresis, nutrition problems, anemias, etc., were also noted in many of the pupils' records. Table 43 indicates the frequencies of findings in this category related to school adjustment and again one finds a greater frequency of physical conditions which were conducive to poor school adjustment in the group of pupils judged as having school difficulties. To sum up, genetic, organic and other health variables as noted in the social work interview appear to have a definite positive relationship to poor school adjustment as judged by the clinical teams.

c. Evidence for psychological factors related to school adjustment as determined from social worker home interviews

The parent-child relationship as inferred from the responses of the parent to the queries of the social worker is definitely related to school adjustment status as can be easily noted by reference to Table 44.

When other adults were present in the home such as a grandmother, uncle, housekeeper, etc., the social worker made note of how the child responded in such relationships. The frequency of positive and negative findings for each sample is noted in Table 45. Evidently only about ten percent of the sample had any other adults in the household or as regular visitors. No definite trend can be found from these data, but the infrequency with which findings were noted suggests that this item should be broadened on future social worker interview schedules to include relationships with other significant adults such as teachers, group leaders, parents in the neighborhood, etc.

Relationships with siblings which were judged by the social worker to have a negative effect on the child's school adjustment are also importantly related to consensus clinical judgment of school adjustment status. Table 46 presents the distributions which indicate also that difficulties in sibling relationship are quite common in most families.

Problems with peers, even though the social workers felt that more inquiry during the interview was needed to cover this question, were also noted more frequently in the sample judged to have poor school adjustment. Table 47 suggests that good relationships with peers may be related to good school adjustment; consequently inquiries directed toward positive as well as negative aspects of peer relationships are important considerations during the home visit.

d. Social factors judged to be related to school adjustment status as noted from social worker interview with parent and observation of home and neighborhood conditions

The great proportion of families seen by the social worker had quite adequate homes so far as economic provisions were concerned. The frequency of economic deprivation can be found in Table 48. When economic deprivation was noted as having a potential negative effect on the child's school adjustment, this fact appears to be linked to clinical judgment of school problems.

A family with minimal economic resources living in a neighborhood of comparable families is in less jeopardy than a family with minimal economic resources in a community where others have a great deal more economic security. In addition social values as inferred from economic status are more in conflict when the family deviates greatly from its surrounding group. Thus the presence of cultural conflict including possible racial, national, religious, class, or urban-rural factors, between the child's parents or between family and neighborhood was routinely examined by the social workers. The presence of negative factors of this type is not uncommon in the project samples. (Table 49)

In the case of both second grade boys and girls, the notation of norm conflict and poor school adjustment status appears to be related. The picture is not as clear for the fifth grade sample, though the same trend is present.

Social disorganization, contrary to evidence for norm conflict was not as common in the families visited by the social workers. Table 50 indicates infrequent neighborhoods which were characterized by social disorganization or anti-social patterns which included the presence of delinquent sub-cultures. These low frequencies are to be expected since the schools which were selected were not ones with serious problems of this sort. Generalizations from the data in this table cannot be made because of the low incidence of social disorganization noted by social workers, but this category should be continued in any social worker investigation of family factors related to school status.

Families move frequently in California. It is a common event for many children. The data on Table 51 do not indicate how frequently families move, but whether such moves are judged by the social worker to be detrimental to the child's school adjustment. No trend can be found which is meaningful, but this may be because the children in the families are still fairly young and the opportunities for moves to take place which would have adversely affected their school standing may not have occurred. In addition the schools selected for this project were in the more stable sections of the school districts so the findings presented in this Table are no doubt what can be expected. Social mobility remains an important category for social workers to judge, and higher frequencies can be expected from the more heterogeneous sections of communities.

The records of 45 pupils were judged to be poorly-adjusted by the clinical teams. Of these, 40 pupils were noted by the social worker to have indications of some factor, physical, psychological or social, which might have affected the child's school progress. This suggests that the social work interview collected meaningful data which were predictive of consensus clinical judgments of poor school adjustment even though some of the items did not provide frequencies large enough to make general statements about their usefulness. (Table 52)

e. Relationship between original teacher rating of school adjustment and consensus clinical judgment of school adjustment status

At least one comparison can be made between teacher rating of school adjustment status and clinical judgment of school problems. That is a scatterplot of the distribution of original rating of school adjustment against consensus clinical judgment. Table 53 presents these data. The correlations for each sample which are noted on Table XI range from .36 to .50 indicating a moderately high positive relationship between teacher and clinical team judgment of school adjustment status. The fact that the correlations are not higher suggests that the differences between teacher judgments and clinical judgments could be clarified by a more detailed comparison of the types of pupils teachers note as having difficulties with the characteristics of the problem-prone population selected by clinicians. Some differences have been noted in the previous tables in the Appendix. The differences, where they exist, do not appear to be a result of teacher oblivion to pupil differences, but to the fact that while the differences are noted, they are not judged by teachers as coincident to school problems. Clinicians, on the other hand, evidently could improve their diagnosis of school problems by sharpening the interview process to collect and evaluate the importance of certain data where trends toward further usability of such data are indicated in the Tables discussed in this section.

With the selection of the method for obtaining criterion measures of school adjustment status for the project pupils, verification that this procedure agreed considerably well with teacher judgment of school adjustment, and that pupils selected at the extremes of this measure differ with respect to a number of variables which were originally discussed as being predictive of school mental health and school adjustment status, Phase One of the project was completed. The next step was to complete Phase Two - the administration of the screening materials in order to get the data which were to be validated against the clinical criterion of school adjustment status.

Chapter VII

ADMINISTRATION OF THE SCREENING MATERIALS

At the time the project was initiated in each of the schools all of the teachers who were to be involved in the Spring of 1962 were invited to a general meeting where the project director reviewed the goals of the project and outlined what would be expected of each participating teacher during the school year. Most of these meetings were held in the months of October and November 1961. Subsequently as the time for the administration of the screening materials approached, nearly all of the teachers were aware of the fact that additional work would be expected of them and their pupils sometime during the Spring semester.

In order to facilitate the screening program, a letter was mailed to all school principals during January 1962 reminding them of the approach of the period for administering the ratings and providing a form on which they could suggest the most appropriate times for their school to be involved in the process. In addition they selected a date on which a meeting with all of the related teachers was to be held in order to review the administration and scoring procedures. In this way maximum flexibility was provided in order to make the extra load of the screening program as comfortable as possible for each of the schools.

A. Teacher meetings prior to the administration of screening process

When the school principals returned their schedule for teacher meetings and administration periods for the screening materials, a final date for the teachers' meeting was set. Names of all the pupils who had been interviewed by the clinicians were compiled for each school and the teachers of all of these pupils were invited to the meeting to discuss the screening program. Prior to the teachers' meeting, the names of all the teachers in the school as well as the number of boys and girls in each class were submitted to the project office. This information was used to prepare packets for each teacher which included the appropriate number of each of the screening materials and accessories. As a rule of thumb, twenty percent more materials than those which were needed by a teacher were included in each packet. This amount was to account for errors in reporting as well as to make adjustments for any new enrollments which could have occurred.

The project director took the materials for the screening program to each school in packets labeled with teacher's name and the number of each test item which was included. Along with tests and scoring materials, each teacher received a Manual and Technical Report. The materials for second grade and fifth grade were prepared according to the following formula:

	Number of Each Item Needed	
Second Grade	Per Teacher	Per Pupil
Technical Report	1	
Manual	1	
Screening Summary	1	
Behavior Ratings of Pupils	1	
Class Record Sheet for A Picture Game	1	
Picture Game Cards (Blue - Boys) (set re-usable)		1 set
Picture Game Cards (Pink - Girls) (set re-usable)		1 set

Second Grade (cont.)	Number of Each Item Needed	
	Per Teacher	Per Pupil
Class Pictures (re-usable)	1	
Teacher's Worksheet for Scoring Peer Ratings	1	
Recording Form for Class Pictures (pad - 30 sheets)	1 (pad)	
Pupil Record Folder		1*

Fifth Grade		
Technical Report	1	
Manual	1	
Screening Summary	1	
Behavior Ratings of Pupils	1	
Thinking About Yourself (Form A - Boys - blue paper)		1*
Thinking About Yourself (Form B - Girls - pink paper)		1*
Class Record Sheet for Thinking About Yourself		1*
Score Sheet for Thinking About Yourself		1*
A Class Play		1*
Teacher's Worksheet for Scoring Peer Ratings	1	
Pupil Record Folder		1*

*1.20 times the number of pupils in each class was entered here and that number of materials included in the packet.

In order to reduce the cost of the materials for a single school, teachers of the second grade pupils shared the boxes with the Picture Game material. The boxes were counted out so that with any combination of boys and girls in the second grade classes in the school, there would be enough for the administration of this self rating to a class at one sitting.

Once the teachers were assembled and all of these materials distributed, the project director again reviewed the purposes of the research and explained the use and application of the screening materials. Questions were invited as the Manual and each rating were reviewed along with the administration instructions which were to be followed. Since every teacher would use the same teacher rating, The Behavior Rating of Pupils, some schools decided to hold the meeting for the second and fifth grade teachers concurrently. In such a case, the procedures for completing the teacher rating were covered first. Next the peer ratings, the Class Pictures for second grade and the Class Play for fifth grade were discussed. In both cases the project director reviewed the instructions in the Manual, asking the teachers to follow the procedures indicated there as closely as possible. The discussion of the administration of the self ratings, The Picture Game for second grade and Thinking About Yourself for fifth grade concluded the review of the screening materials.

B. Obtaining teacher and principal nominations of specific behavior problems

A second round of nominations of pupils with specific behavior problems, similar to the one made at the beginning of the project, was required of the teachers of the project pupils prior to their administration of the screening materials. The instructions for making the nominations and the form on which they were made is included in the Appendix. This material was distributed to the teachers and their principal at the teacher meeting. All the staff were to complete the form within two days and the materials were then forwarded to the project office. The purpose of the nomination procedure was to gather data to estimate the proportion of pupils at each grade level falling into each of the behavior categories listed on the form and to compare characteristics of pupils who were nominated with those of pupils who had not been seen by teachers or principals as having specific behavior problems..

C. Informing parents of the school's intention to conduct the special testing program

In order to allay the anxiety of any parent who discovered that his child was taking tests which were different from those usually administered at school, a notice was sent home to all parents of the pupils in the classes where the screening was to take place. A sample of the letter which was designed for use by the school can be found in the Appendix. Any parent who had reason to object to his child's participation in the screening procedures could request that the pupil be excused from class on the days that the peer and self ratings were to be administered. Such a procedure follows the policy initiated at the start of the project: that the school has the responsibility of obtaining the sanction of parents before submitting children to examination procedures different from those which are normally followed. When screening programs such as the one described in this report become commonly understood as lying within the purview of the school, as vision and hearing screening procedures are now, such an extra step will not be necessary. Until that time, however, parents should be apprised of the purpose and general procedures of research and special testing programs in the school.

D. Assisting the teachers with test administration and scoring

Every effort was made in advance of the administration of the screening materials to insure teacher cooperation. At each school, help was offered with administration of the tests or assistance with scoring and tabulating the materials after they were administered. Many teachers wished to do their own work; however, if they felt the additional burden was too heavy for them, they had to complete only the *Behavior Rating of Pupils* and the administration of the peer and self ratings. After checking the pupil's work on each of the tests for legibility and a listing of both first and last name on the peer rating, the teachers returned all of their materials along with a class roster to the project office for scoring. The ratings were then turned over to a research assistant who scored all of the materials and then recorded the scores and pupil code numbers on the documents for data processing.

At the end of the screening program, scores on teacher, peer and self ratings were available for all of the classmates of the project pupils, as well as the project pupils themselves. Thirty-four teachers at both second and fifth grade level, and approximately 1100 pupils at each grade level were involved in the screening procedure. The data from the screening materials as well as the nominations of pupils with specific behavior problems by teachers and the school principals comprise, then, the data collected from the screening phase of the project.

Chapter VIII

RESULTS OF THE STUDY

A. Value of Existing Procedures Already Established in School for Screening Purposes

Obviously the efficacy of a screening procedure which involves entire school populations can be established only after one determines the value of existing or easily developed school procedures for screening purposes.

1. Use of School Referrals as a Means of Locating Pupils with Learning and Behavior Difficulties.

Since school records were reviewed for all of the children involved in the administration of the screening materials, the number of referrals which were made on any of the project pupils could be surveyed to determine the degree to which school referral might be a practical screening procedure. From the cumulative records referrals to guidance offices, referrals for child welfare and attendance services (usually excessive absences or truancies) health referrals, and referrals for assistance with speech problems were noted. Referrals to guidance offices might have requested an individual test to establish eligibility for remedial reading programs, placement in classes for the gifted, or to request a complete case study of a pupil with learning and behavior difficulties. Child welfare and attendance referrals are typically made by the school principal's office or the school nurse. Health referrals are made most frequently by the school nurse or in some cases as a follow-up of a visit to the school by the school district physician. Speech referrals often depend on the availability of a speech therapist to a school. When a speech therapy program is conducted in a particular school, teachers may make referrals or the speech therapist himself may conduct the screening program to select candidates for his services.

Table XXII indicates the number and percent of pupils referred to the guidance office, for health reasons or for speech services. None of the project pupils had been referred to the child welfare and attendance office for follow-up investigation of absences or for other reasons. The surprising fact about this table is that only eight of the 301 project pupils had been referred to the guidance office and that half of these were in one school, and the remainder in only two schools. Either availability of guidance personnel, long waiting lists or some other reason must explain the fact that no more than this few number of pupils had had any type of contact with the school guidance office. A review of the case materials on those who had been referred indicates that they are not necessarily in the group with the poorest school adjustment in the project sample. At least one pupil was referred for the school's gifted program, and one or two more were referred to determine eligibility for the school remedial reading program.

Speech referrals were also sparse, but this is to be expected since all schools do not have speech specialists to assist pupils with articulatory and developmental speech problems. The most common referral was that for health follow-up. The differing percentages of health referrals in the various schools seems to be more a result of the availability of the services of the school physician than the fact that some schools have fewer health problems among the student population, though these variables may interact to produce the given percentages. From a cursory review of the health records of the project pupils, there were several types of health referrals which apparently depended on the type of health

TABLE XXII

Frequency and Percent of Project Pupils in Each School Referred Prior to Project 1186 for Guidance, Health or Speech Services

School Code	Type of Referral			N (Project Sample)
	Guidance	Health	Speech	
01	4 (20%)	5 (25%)	2 (10%)	20
02				9
03		14 (35%)		40
04		6 (16%)	6 (16%)	36
05	3 (10%)	12 (39%)	1 (3%)	31
06		2 (9%)	1 (5%)	22
07		11 (30%)	1 (3%)	37
08	1 (3%)	6 (20%)		31
09		2 (5%)		37
10			1 (4%)	25
11		1 (7%)		13
Total Number of Pupils Referred	8 (3%)	59 (20%)	12 (4%)	301

screening program which had been conducted in the school. For example, if the school dentist had visited the school many pupils took home referrals to the family dentist or school dental clinic and this fact was noted on their card. Heart murmurs, wax in the ears, posture, vision and hearing, and nutrition referrals were also commonly found.

School referrals cannot, therefore, be routinely accepted as a school criterion of learning and behavior problems since availability of services and other selective factors appear to account for the referrals which were noted among the pupils in the project sample. Some type of screening procedure beyond the use of teacher referrals is imperative in order to achieve the goal of early identification of learning and behavior difficulties.

2. Use of Teacher Nominations as a Means of Locating Pupils with Learning and Behavior Difficulties

All of the nominations made by teachers and principals prior to the administration of the screening materials were recorded for each pupil and incorporated into the key punched data for later comparisons. Five types of nominations were made: 1) An inability to learn which cannot be adequately explained by intellectual, sensory, neurophysiological or general health factors; 2) An inability to build or maintain satisfactory interpersonal relationships with peers and teachers; 3) Inappropriate or immature types of behavior or feelings under normal circumstances; 4) A general pervasive mood of unhappiness or depression; and 5) A tendency to develop physical symptoms, such as speech problems, pains or fears associated with personal or school difficulties. Table XXIII provides the distribution of each nomination by school and grade for the project sample. Altogether one fourth of the project pupils were nominated for some type of problem. The most frequent problem noted was an inability to learn and the least frequent nomination was inappropriate or immature behavior. Again differences can be found among the schools which cannot be readily explained by noted school characteristics.

In order to determine the degree to which being nominated by the principal or teacher as having one of the above specific school problems was in agreement with other criteria of school adjustment status, three types of comparisons were made: 1) specific nominations compared with teacher rating of school adjustment made prior to the start of the project, 2) specific nominations were compared with consensus clinical judgment of good and poor school adjustment (the same groups used in Chapter VI to compare case findings), 3) the distribution of clinical criterion scores for all pupils who were nominated.

a. Distribution of Original Teacher Rating for Pupils with Nominations of Specific School Problems

Tables XXIV through XXVIII contain the distributions of original teacher rating of school adjustment for pupils with a nomination one year later by teacher or principal as one with specific learning and behavior problems. Remembering that a teacher rating of "1" indicates the best school adjustment and that "7" indicates poorest school adjustment, one can readily interpret these tables by noting the degree to which the pupils who received nominations were earlier rated by their teachers as having school adjustment difficulties. In a few cases pupils who were nominated received earlier teacher ratings of "1", "2" or "3" indicating good school adjustment as perceived by the teacher but the predominate number of nominees were also rated by the teachers as having average or poorer school adjustment status.

TABLE XXIII

Frequency and Percent of Project Pupils in Each School in Grade 2 and 5 Nominated by Teachers or Principals Prior to Screening Program as Having Specific School Problems

Nominated as:	School Code											Total Number of Pupils Nominated	Percent of Project Pupils Nominated**
	01	02	03	04	05	06	07	08	09	10	11		
1. Unable to learn													
Grade 2	1		2	1	2	2	2	1	2	1	1	33	(11%)
Grade 5		1	2		3	1	2	4	1	2	2		
2. Having problems in interpersonal relations													
Grade 2	1				3		3	1	1			19	(6%)
Grade 5	1	1	1	1			2	1	2	1			
3. Having inappropriate behavior													
Grade 2		2	1								1	13	(4%)
Grade 5		1	2	1	2		1		1	1			
4. Unhappy or depressed													
Grade 2	1	2	1		1	1	2	1	1			23	(8%)
Grade 5	1		1	2	2	2	2	1		1	1		
5. Having somatic symptoms associated with stress													
Grade 2			1	1				3	1	1	1	15	(5%)
Grade 5	1			1			2	1		2			
Percent of Project Pupils Nominated by School*	25%	67%	25%	16%	32%	37%	30%	32%	16%	20%	38%	77*	(26%)

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* Each pupil is accounted for only one time in case of multiple nomination.

** Percent figured on basis of number of nominations; therefore some pupils may have only one entry, others may have more than one.

TABLE XXIV

Principal or Teacher Nomination Prior to Screening Program as a Child with Marked Learning Difficulties Compared with Original Teacher Rating of School Adjustment

	Not Nominated	Nominated	Total Number Interviewed
2nd Grade Girls			
Original Teacher Rating			
1	4	0	4
2	8	0	8
3	23	0	23
4	8	0	8
5	14	1	15
6	10	0	10
7	6	1	7
Total	73	2	75
2nd Grade Boys			
Original Teacher Rating			
1	7	2	9
2	8	0	8
3	9	0	9
4	7	0	7
5	10	3	13
6	15	4	19
7	7	2	9
Total	63	11	74
5th Grade Girls			
Original Teacher Rating			
1	2	0	2
2	8	0	8
3	4	0	4
4	17	2	19
5	9	1	10
6	6	1	7
7	4	1	5
Total	50	5	55
5th Grade Boys			
Original Teacher Rating			
1	4	0	4
2	10	0	10
3	10	0	10
4	19	3	22
5	19	3	22
6	16	5	21
7	5	2	7
Total	83	13	96

TABLE XXV

Teacher or Principal Nomination Prior to Screening Program As a Child With Marked Difficulty in Interpersonal Relationships Compared with Original Teacher Rating of School Adjustment

	Not Nominated	Nominated	Total Number Interviewed
2nd Grade Girls			
Original Teacher Rating			
1	4	0	4
2	8	0	8
3	23	0	23
4	8	0	8
5	15	0	15
6	10	0	10
7	6	1	7
Total	74	1	75
2nd Grade Boys			
Original Teacher Rating			
1	7	2	9
2	8	0	8
3	9	0	9
4	6	1	7
5	11	2	13
6	15	4	19
7	9	0	9
Total	65	9	74
5th Grade Girls			
Original Teacher Rating			
1	2	0	2
2	8	0	8
3	4	0	4
4	19	0	19
5	10	0	10
6	5	2	7
7	5	0	5
Total	53	2	55
5th Grade Boys			
Original Teacher Rating			
1	4	0	4
2	10	0	10
3	10	0	10
4	20	2	22
5	22	0	22
6	18	3	21
7	4	3	7
Total	88	8	96

TABLE XXVI

Teacher or Principal Nomination Prior to Screening Program As a Child With Unusual or Inappropriate Behavior Compared With Original Teacher Rating of School Adjustment

	Not Nominated	Nominated	Total Number Interviewed
2nd Grade Girls			
Original Teacher Rating			
1	4	0	4
2	8	0	8
3	22	1	23
4	8	0	8
5	14	1	15
6	10	0	10
7	7	0	7
Total	73	2	75
2nd Grade Boys			
Original Teacher Rating			
1	8	1	9
2	8	0	8
3	9	0	9
4	7	0	7
5	13	0	13
6	19	0	19
7	8	1	9
Total	72	2	74
5th Grade Girls			
Original Teacher Rating			
1	2	0	2
2	8	0	8
3	4	0	4
4	17	2	19
5	10	0	10
6	5	2	7
7	5	0	5
Total	51	4	55
5th Grade Boys			
Original Teacher Rating			
1	4	0	4
2	9	1	10
3	10	0	10
4	22	0	22
5	21	1	22
6	19	2	21
7	7	0	7
Total	92	4	96

TABLE XXVII

Teacher or Principal Nomination Prior to Screening Program
As a Child Often Unhappy or Depressed
Compared with Original Teacher Rating of School Adjustment

	Not Nominated	Nominated	Total Number Interviewed
2nd Grade Girls			
Original Teacher Rating			
1	4	0	4
2	6	2	8
3	23	0	23
4	7	1	8
5	15	0	15
6	9	1	10
7	7	0	7
Total	71	4	75
2nd Grade Boys			
Original Teacher Rating			
1	9	0	9
2	8	0	8
3	9	0	9
4	7	0	7
5	12	1	13
6	17	2	19
7	7	2	9
Total	69	5	74
5th Grade Girls			
Original Teacher Rating			
1	2	0	2
2	8	0	8
3	4	0	4
4	19	0	19
5	10	0	10
6	7	0	7
7	5	0	5
Total	55	0	55
5th Grade Boys			
Original Teacher Rating			
1	4	0	4
2	10	0	10
3	10	0	10
4	18	4	22
5	20	2	22
6	15	6	21
7	4	3	7
	81	15	96

TABLE XXVIII

Teacher or Principal Nomination Prior to Screening Program As a Child Who Often Gets Upset Or Sick When Faced With Difficulties Compared With Original Teacher Rating of School Adjustment

	Not Nominated	Nominated	Total Number Interviewed
2nd Grade Girls Original Teacher Rating			
1	4	0	4
2	8	0	8
3	22	1	23
4	8	0	8
5	14	1	15
6	10	0	10
7	5	2	7
Total	71	4	75
2nd Grade Boys Original Teacher Rating			
1	9	0	9
2	8	0	8
3	9	0	9
4	6	1	7
5	13	0	13
6	16	3	19
7	9	0	9
Total	70	4	74
5th Grade Girls Original Teacher Rating			
1	2	0	2
2	8	0	8
3	4	0	4
4	19	0	19
5	8	2	10
6	4	3	7
7	5	0	5
Total	50	5	55
5th Grade Boys Original Teacher Rating			
1	4	0	4
2	10	0	10
3	10	0	10
4	22	0	22
5	21	1	22
6	21	0	21
7	7	0	7
Total	95	1	96

b. Comparison of Teacher Nomination and Consensus Clinical Judgment of Good and Poor School Adjustment

Tables XXIX through XXXIII contain the comparisons of consensus clinical judgment of school adjustment with the nomination status of second and fifth grade boys and girls. These tables have the disadvantage that the equivocal groups contain the majority of nominees and one is not able to tell whether those in the middle group are closer to one or the other end of the distribution of clinical criterion scores. These tables are useful, however, when compared with the tables in the Appendix which describe the project pupils on the same basis. Five nominees out of 77 were judged as well adjusted by the clinical teams, and the remainder were in the equivocal or poorly adjusted group.

c. Clinical Criterion Scores for Pupils Nominated by Teacher or Principal as Having Specific Learning and Behavior Problems

The data on Table XXXIV indicate that approximately 30 percent of pupils who receive nominations of specific learning and behavior problems by either principal or teacher are rated by the clinical team as having average or better school adjustment. The lack of agreement is a function of differing perceptions of pupils by clinicians and teachers and the fact that a specific behavior characteristic which can usually considered to be indicative of serious learning and behavior problems, may be handled quite well by an individual pupil as he meets school and other life situations. Perfect agreement in any case (or at least having all cases which are nominated receive an above average criterion score) is not expected. The inference from Table XXXIV is that when teachers or principals nominate a pupil as having a specific learning or behavior problem, the probability is about seven chances in ten that the pupil will be judged by a clinical team to be poorer than average in school adjustment.

While teacher referral has been demonstrated to be a poor means of locating pupils with potential school adjustment problems, nomination procedures such as those followed in this project appear to locate pupils who are judged by a previous teacher or by a clinical team who should be candidates for follow-up diagnostic evaluations. The weakness of the nomination procedure is that normative procedures are difficult to develop; therefore the number of pupils and the severity of their problems will vary from school to school. As a means of getting teachers and principals involved in a screening program, the nomination phase has great value.

B. Results of Administration of the Screening Process

1. The Findings From the Behavior Rating of Pupils

Teachers of the pupils who were interviewed by the clinical team rated all of the pupils in their class, including the project pupils, on the Behavior Rating of Pupils. The form of the ratings is identical to the form used for the original rating of school adjustment. Seven rating categories are used and the teacher distributes the entire class on one behavior item before going on to the next. Thus each item of the eight items on the teacher rating is rated separately. The pupils in the class are distributed on each rating according to the teachers perception of their behavior on that trait. With this procedure halo effect and other forms of rater bias are held to a minimum. Since all teachers use a similar form for their ratings, a high rating of two pupils in different classrooms can be considered to reflect a comparable perception of behavior from teacher to teacher. While

TABLE XXIX

Comparison of Whether Nominated by Teacher Prior to Screening As "Unable to Learn" and Consensus Clinical Judgment of Good and Poor School Adjustment

	Not Nominated	Nominated	Total Number Interviewed
2nd Grade Girls			
Clinical Group			
1. Consensus Well Adjusted	14	0	14
2. Neither Well Nor Poorly Adjusted	50	1	51
3. Consensus Poorly Adjusted	9	1	10
Total	73	2	75
2nd Grade Boys			
Clinical Group			
1. Consensus Well Adjusted	9	1	10
2. Neither Well Nor Poorly Adjusted	46	4	50
3. Consensus Poorly Adjusted	8	6	14
Total	63	11	74
5th Grade Girls			
Clinical Group			
1. Consensus Well Adjusted	11	0	11
2. Neither Well Nor Poorly Adjusted	36	5	41
3. Consensus Poorly Adjusted	3	0	3
Total	50	5	55
5th Grade Boys			
Clinical Group			
1. Consensus Well Adjusted	5	0	5
2. Neither Well Nor Poorly Adjusted	64	8	72
3. Consensus Poorly Adjusted	14	5	19
Total	83	13	96

TABLE XXX

Comparison of Whether Nominated by Teacher Prior to Screening as "Difficulty in Interpersonal Relationships" And Consensus Clinical Judgment of Good and Poor School Adjustment

	Not Nominated	Nominated	Total Number Interviewed
2nd Grade Girls Clinical Group			
1. Consensus Well Adjusted	14	0	14
2. Neither Well Nor Poorly Adjusted	51	0	51
3. Consensus Poorly Adjusted	9	1	10
Total	74	1	75
2nd Grade Boys Clinical Group			
1. Consensus Well Adjusted	9	1	10
2. Neither Well Nor Poorly Adjusted	44	6	50
3. Consensus Poorly Adjusted	12	2	14
Total	65	9	74
5th Grade Girls Clinical Group			
1. Consensus Well Adjusted	11	0	11
2. Neither Well Nor Poorly Adjusted	40	1	41
3. Consensus Poorly Adjusted	2	1	3
Total	53	2	55
5th Grade Boys Clinical Group			
1. Consensus Well Adjusted	4	1	5
2. Neither Well Nor Poorly Adjusted	68	4	72
3. Consensus Poorly Adjusted	16	3	19
Total	88	8	96

TABLE XXXI

Comparison of Whether Nominated by Teacher Prior to Screening as Having "Inappropriate Behavior" and Consensus Clinical Judgment of Good and Poor School Adjustmen

	Not Nominated	Nominated	Total Number Interviewed
2nd Grade Girls			
Clinical Group			
1. Consensus Well Adjusted	14	0	14
2. Neither Well Nor Poorly Adjusted	51	0	51
3. Consensus Poorly Adjusted	8	2	10
Total	73	2	75
2nd Grade Boys			
Clinical Group			
1. Consensus Well Adjusted	9	1	0
2. Neither Well Nor Poorly Adjusted	50	0	50
3. Consensus Poorly Adjusted	13	1	14
Total	72	2	74
5th Grade Girls			
Clinical Group			
1. Consensus Well Adjusted	11	0	11
2. Neither Well Nor Poorly Adjusted	37	4	41
3. Consensus Poorly Adjusted	3	0	3
Total	51	4	55
5th Grade Boys			
Clinical Group			
1. Consensus Well Adjusted	5	0	5
2. Neither Well Nor Poorly Adjusted	69	3	72
3. Consensus Poorly Adjusted	18	1	19
Total	92	4	96

TABLE XXXII

Comparison of Whether Teacher Nominated Prior to Screening as "Often Unhappy or Depressed" and Consensus Clinical Judgment of Good and Poor School Adjustment

	Not Nominated	Nominated	Total Number Interviewed
nd Grade Girls			
linical Group			
1. Consensus Well Adjusted	14	0	14
2. Neither Well Nor Poorly Adjusted	48	3	51
3. Consensus Poorly Adjusted	9	1	10
otal	71	4	75
d Grade Boys			
inical Group			
1. Consensus Well Adjusted	10	0	10
2. Neither Well Nor Poorly Adjusted	47	3	50
3. Consensus Poorly Adjusted	12	2	14
tal	69	5	74
h Grade Girls			
inical Group			
1. Consensus Well Adjusted	11	0	11
2. Neither Well Nor Poorly Adjusted	41	0	41
3. Consensus Poorly Adjusted	3	0	3
tal	55	0	55
h Grade Boys			
inical Group			
1. Consensus Well Adjusted	4	1	5
2. Neither Well Nor Poorly Adjusted	62	10	72
3. Consensus Poorly Adjusted	15	4	19
al	81	15	96

TABLE XXXIII

Comparison of Whether Teacher Nominated Prior To Screening as "Often Gets Upset Or Sick" and Consensus Clinical Judgment of Good and Poor School Adjustment

	Not Nominated	Nominated	Total Number Interviewed
2nd Grade Girls Clinical Group			
1. Consensus Well Adjusted	14	0	14
2. Neither Well Nor Poorly Adjusted	48	3	51
3. Consensus Poorly Adjusted	9	1	10
Total	71	4	75
2nd Grade Boys Clinical Group			
1. Consensus Well Adjusted	10	0	10
2. Neither Well Nor Poorly Adjusted	46	4	50
3. Consensus Poorly Adjusted	14	0	14
Total	70	4	74
5th Grade Girls Clinical Group			
1. Consensus Well Adjusted	11	0	11
2. Neither Well Nor Poorly Adjusted	37	4	41
3. Consensus Poorly Adjusted	2	1	3
Total	50	5	55
5th Grade Boys Clinical Group			
1. Consensus Well Adjusted	5	0	5
2. Neither Well Nor Poorly Adjusted	72	0	72
3. Consensus Poorly Adjusted	18	1	19
Total	95	1	96

TABLE XXXIV

Distribution of Scores on Clinical Criterion of School Adjustment For All Project Pupils Nominated as Having Specific School Problems

Clinical Criterion Score	Group 2nd Grade Girls	 2nd Grade Boys	 5th Grade Girls	 5th Grade Boys
3				
4		1		1
5		1		
6	1	2		1
7	2	3	1	1
8	1			4
9		2	3	2
10	2	3	3	4
11		3	5	4
12	2	4	1	5
13	1	2		2
14	2	1		4
15		2	1	1
Total Number Nominated	11	23	14	29
Total Number of Project Pupils	75	74	55	96
Percent of Pupils Nominated	15%	31%	25%	30%

differences in school populations from school to school remain to be evaluated in the use of such a rating procedure, the results from this teacher rating indicate enough comparability from class to class that the inference of comparability of ratings appears justified. The reader should keep in mind that boys and girls are not separated for this rating procedure. The teacher orders the entire class on the basis of how she perceives the class members on a particular trait.

a. Norms by Grade and Sex for Behavior Rating of Pupils

Even though the rating which is presented to the teachers on the Behavior Rating of Pupils requires a distribution of ratings in an approximate normal distribution, teachers are not held to this requirement. Enough flexibility is provided in each column to allow for class differences to show up, for skewed or rectangular distributions in some cases or for differences in distribution of ratings for items within a single class. Table XXXV lists the items on the teacher rating, distributions of ratings, means and standard deviations for all second grade pupils. Table XXXVI provides the same listing for fifth graders.

b. Comparison of Teacher Rating Items With Clinical Criterion of School Adjustment Status

The rating procedure required of the teachers and the resulting approximate normal distribution lends itself nicely to a check on the validity of the Behavior Rating of Pupils in predicting the clinical criterion score of school adjustment status. Table XXXVII lists the correlations for each grade and sex group for all items on the teacher rating and the sum of all the item ratings with the clinical criterion score. Item "E", "This pupil works extremely hard in learning school subjects to the exclusion of all other activities", which was designed to locate the type of behavior characterized by the obsessive pupil who finds security in devoting all of his energies to the safety of school work, is rated in the reverse direction to the other items. This indicates that as teachers perceive this trait it is negatively correlated with clinical criterion of school adjustment. This item, therefore, contributes to a weakening of the total score in that it gives a higher rating than expected to the well adjusted pupils, and a lower rating to the poorly adjusted ones. In a previous teacher rating (75) the item, "This pupil is interested in activities which he can do himself" was also negatively correlated with a criterion of school adjustment status. The present item is an attempt to improve on the earlier one, but the effort was not rewarded.

The only other interesting finding on Table XXXVII is the fact that the first item, "This pupil gets into fights or quarrels with other pupils," has an insignificant correlation with the clinical criterion in all groups with the exception of fifth grade boys. Evidently the behavior which clinicians select is not related to the teacher's perception of interpersonal difficulty in the classroom. This result suggests a modification of the interview schedules of the team members to incorporate more data on peer relationships, rather than an inadequate rating item. The other significantly low correlations, item "D" and "F" for fifth grade girls and item "B" for fifth grade boys suggest differences in teacher-clinician perception rather than invalid rating items. No reliability check was made of the teacher rating. This was necessitated because of time limitations in theproject which did not allow for a readministration of the rating at a later date. Since the rating items are designed to measure different types of behavior, reliability estimates based on internal consistency procedures are not appropriate, and only a retest reliability would be applicable. The validity of the Behavior Rating of Pupils not only in terms of items, but

TABLE XXXV

Frequency of Ratings, Means, and Standard Deviations
On Items of Behavior Rating of Pupils (Teacher Rating).
All Second Grade Girls and Boys

Item	Sex	Frequency of Rating							N	Means	Standard Deviation
		1	2	3	4	5	6	7			
A. Gets into fights or quarrels with other pupils	Girls	48	89	118	140	72	45	8	513	3.56	1.37
	Boys	22	52	70	137	122	89	61	553	4.44	1.57
B. Has to be coaxed or forced to work with others	Girls	46	74	103	125	90	50	26	514	3.76	1.56
	Boys	26	62	92	163	99	76	35	553	4.11	1.36
C. Has difficulty learning	Girls	43	83	104	139	87	46	12	514	3.64	1.45
	Boys	33	54	83	138	99	89	57	553	4.28	1.65
D. Makes unusual or inappropriate responses during school	Girls	52	87	101	154	71	34	14	513	3.51	1.44
	Boys	23	53	87	126	112	95	55	551	4.37	1.59
E. Works extremely hard in learning school subjects	Girls	20	47	85	148	111	77	25	513	4.91	1.41
	Boys	58	91	102	142	73	54	33	553	3.68	1.19
F. Behaves in ways which are dangerous to self or others	Girls	50	96	121	128	61	36	7	499	3.38	1.43
	Boys	28	38	69	141	122	84	52	534	4.41	1.59
G. Is unhappy or depressed	Girls	49	69	110	132	83	47	23	513	3.71	1.80
	Boys	25	61	79	147	104	86	51	553	4.28	1.59
H. Becomes upset or sick often, especially when faced with a difficult school problem	Girls	35	74	95	124	79	59	34	500	3.90	1.63
	Boys	37	56	91	151	103	64	33	535	4.03	1.50
Total Rating	Girls									30.11	7.10
	Boys									34.04	7.32

TABLE XXXVI

Frequency of Ratings, Means, and Standard Deviations On Items of Behavior Rating of Pupils (Teacher Rating). All Fifth Grade Girls and Boys

Item	Sex	Frequency of Rating							N	Means	Standard Deviation
		1	2	3	4	5	6	7			
A. Gets into fights or quarrels with other pupils	Girls	50	85	132	157	80	50	11	565	3.57	1.39
	Boys	32	61	93	155	127	88	60	616	4.28	1.59
B. Has to be coaxed or forced to work with others	Girls	26	60	111	170	103	57	37	564	4.03	1.43
	Boys	55	84	97	162	105	77	33	613	3.88	1.60
C. Has difficulty learning	Girls	49	70	123	152	94	55	23	566	3.76	1.47
	Boys	38	82	105	146	105	84	55	615	4.09	1.64
D. Makes unusual or inappropriate responses during school	Girls	52	93	119	164	69	39	11	547	3.49	1.42
	Boys	33	52	81	143	133	95	66	603	4.39	1.67
E. Works extremely hard in learning school subjects	Girls	15	41	88	167	117	84	38	550	4.33	1.41
	Boys	62	102	123	157	82	47	25	598	3.56	1.59
F. Behaves in ways which are dangerous to self or others	Girls	54	81	131	160	75	37	12	550	3.51	1.60
	Boys	25	61	66	157	130	101	59	599	4.41	1.61
G. Is unhappy or depressed	Girls	41	68	98	138	83	74	28	530	3.92	1.61
	Boys	34	69	106	160	111	64	42	586	4.03	1.56
H. Becomes upset or sick often, especially when faced with a difficult school problem	Girls	38	62	97	131	99	63	32	522	3.97	1.58
	Boys	34	62	96	160	101	70	38	561	4.06	1.49
Total Rating	Girls									31.00	6.45
	Boys									32.99	7.07

TABLE XXXVII

Correlation of Items of Behavior Rating of Pupils With Clinical Criterion of School Adjustment

Item	Group			
	2nd Grade Girls	2nd Grade Boys	5th Grade Girls	5th Grade Boys
A. Gets into fights or quarrels with other pupils	-0.073*	.154*	-0.049*	.402
B. Has to be coaxed or forced to work with others	.380	.323	.513	.175*
C. Has difficulty learning	.358	.559	.508	.479
D. Makes unusual or inappropriate responses during school	.266	.484	.250*	.342
E. Works extremely hard in learning school subjects	-0.181*	-0.363	-0.335	-0.361
F. Behaves in ways which are dangerous to self or others	.238	.338	.095*	.450
G. Is unhappy or depressed	.249	.250	.493	.473
H. Becomes upset or sick often, especially when faced with a difficult school problem	.234	.283	.515	.344
Total	.308	.425	.511	.530

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* Not significant

also in terms of total score is indicated by the correlation of the item scores and total score with the clinical criterion. With the exception of Item "E" the remaining items appear to provide a meaningful and useful measure of pupil behavior in terms of teachers' perception.

2. Findings From the Administration of the Peer Ratings - Class Pictures to Second Grade Pupils and Class Play to Fifth Grade Pupils

After the teachers completed the *Behavior Rating of Pupils*, they were next to administer the peer ratings and self ratings to all of the pupils in their class. Usually the peer ratings were given first. Earlier in the report both the *Class Pictures* and the *Class Play* were described. Both ratings require pupils in the class to select classmates for both positive and negative roles depicted in pictures (second grade) or described in hypothetical parts in a play which the class might be planning (fifth grade). There are twenty items on both ratings half of which represent positive, acceptable, or neutral roles, and twenty which describe negative, undesirable or maladaptive behavior. Each pupil selects one of his classmates for each of the twenty statements. Both the instruments are scored in the same way. First all of the peer selections for a particular pupil are tallied from the ratings made by all the members of the class. Next the total number of times the child was selected for any of the twenty parts is determined. The number of times those selections were for the negative (even numbered) roles is also determined. From these two totals the percent of negative perception is determined. Both administration and scoring instructions follow procedures detailed in the *Manual for a Process for In-School Screening of Children With Emotional Handicaps* (20).

Previous research (75) on both of the peer ratings has shown the individual items to be generally predictive of whether or not a pupil is later determined to have difficulties in school, and the percent of negative selections has been shown to be significantly different for pupils who are selected as having learning and behavior problems from those who are not selected as ones with school difficulties.

In Project 1186 the validity of the peer rating items as well as the validity of the summary scores was to be established by comparing item scores with the clinical criterion of school adjustment status. Of interest to the reader should be the distribution of the proportion of selections for particular items for girls and boys of both grades. These along with a brief statement of the item are listed on Table XXXVIII for second grade and Table XXXIX for fifth grade. The data for *Class Pictures* also indicate the sex of the pupil in the picture for a particular item. Distributions for these items should be compared with this in mind. The items on the *Class Play* with a few exceptions do not have "boy" or "girl" named in the item statement so there is a greater possibility of an equivalent number of peer selections of both boys and girls for each item. Some items on both peer ratings, nevertheless, are chosen more often for boys than for girls and vice versa. In all cases the distributions are curvilinear with the predominant number of choices either zero or 1.

The validity of each item was determined by comparing the correlation of the number of selections for pupils on each item with their clinical criterion scores. Since the distributions are not normal, low correlations are to be expected. Only a small number of them in both ratings are found to be significant. An r of .225 is needed for both second grade boys and girls, .288 is required for firth grade girls and .200 for fifth grade boys to be significantly different from chance at the 5% level. Negative correlations with the criterion score are expected for all of the odd numbered items since children with learning and behavior problems would be selected less for these items with statements of desirable traits and positive correlations should

TABLE XXXVIII

Distribution of Proportions of Frequency of Peer Selection on Items of Class Play and Correlation of Item for Project Pupils with Clinical Criterion Second Grade Boys and Girls*

Item Picture	Sex	Proportion of Pupils With Each Frequency of Peer Selection						r for project sample with clinical criter.	**
		0-1	2-3	4-5	6-7	8-9	10-18		
1. A boy listening to his teacher	Boys	.66	.21	.06	.03	.01	.03	-.253	+
	Girls	.94	.03	.01	.01	.00	.01	-.029	+
2. A girl talking to her friend while the teacher is talking.	Boys	.94	.04	.01	.00	.01		.024	+
	Girls	.66	.21	.06	.04	.02	.01	-.123	-
3. A girl having fun on the swings.	Boys	.94	.04	.01	.00	.00	.01	.034	-
	Girls	.61	.27	.07	.03	.01	.01	-.166	+
4. A girl chasing a boy trying to hit him.	Boys	.93	.05	.01	.01			.171	+
	Girls	.69	.18	.07	.03	.01	.02	-.131	-
5. A boy playing ball with other children.	Boys	.56	.29	.09	.03	.02	.01	-.150	+
	Girls	.98	.01	.01				-.117	+
6. A boy fighting with this other boy.	Boys	.88	.00	.08	.00	.00	.04	.250	+
	Girls	.99	.00	.01				0	0
7. A boy playing kick ball with other children.	Boys	.57	.29	.09	.02	.02	.01	-.166	+
	Girls	.98	.01	.01				-.017	+
8. An unhappy boy watching other children play.	Boys	.61	.29	.07	.01	.00	.02	.134	+
	Girls	.97	.02	.00	.00	.01		-.088	-
9. A boy carrying milk back to class.	Boys	.63	.25	.08	.02	.01	.01	-.215	+
	Girls	.96	.01	.01	.01	.00	.01	-.271	+
10. A sick girl in the nurse's office.	Boys	.95	.03	.00	.00	.01	.01	.093	+
	Girls	.63	.25	.07	.02	.01	.02	-.137	-
11. A happy child (girl)	Boys	.97	.01	.01	.01			-.116	+
	Girls	.52	.32	.11	.04	.01		-.081	+
12. A girl being brought to school by her mother	Boys	.94	.04	.01	.00	.00	.01	.203	+
	Girls	.68	.23	.05	.03	.00	.01	-.141	-
13. A boy playing on the bars.	Boys	.95	.03	.02				-.088	+
	Girls	.94	.05	.00	.01			-.224	+
14. A boy who seems to be having a stomach ache.	Boys	.62	.29	.07	.01			.093	+
	Girls	.95	.04	.00	.01			.090	+
15. A girl walking along with her friends.	Boys	.98	.01	.01				.043	-
	Girls	.50	.35	.11	.02	.01	.01	.088	-

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* For proportions N = 581 boys, N = 554 girls
For correlations between clinical criterion and item score N = 75 boys, N = 74 girls.

** + = distribution in expected direction
- = distribution not in expected direction

TABLE XXXVIII - cont.

Item Picture	Sex	Proportion of Pupils With Each Frequency of Peer Selection						r for project sample with clinical criter. **	
		0-1	2-3	4-5	6-7	8-9	10-18		
16. A girl fighting with another child.	Boys	.94	.04	.02				.048	-
	Girls	.68	.21	.06	.02	.01	.02	.019	-
17. A girl working quietly at the table.	Boys	.93	.05	.02				-.188	-
	Girls	.60	.27	.09	.01	.01	.02	.025	-
18. A boy playing with toys while the rest of the class is working.	Boys	.89	.00	.08	.00	.00	.03	.300	-
	Girls	.98	.02					-.007	-
19. A girl playing tether ball	Boys	.91	.06	.01	.01	.01		-.107	+
	Girls	.63	.29	.05	.02	.00	.01	-.172	-
20. A boy being told by the teacher not to do something.	Boys	.90	.00	.06				.097	-
	Girls	.98	.01	.00	.01			.029	-

** + = distribution in expected direction
- = distribution not in expected direction

TABLE XXXIX

Distribution of Proportions of Frequency of Peer Selection On Items of Class Play and Correlation of Item for Project Pupils With Clinical Criterion--Fifth Grade Boys and Girls*

Item one who could play part of:	Sex	Proportion of Pupils With Each Frequency of Peer Selection						r for Project Sample With Clinical Criter.	**
		0-1	2-3	4-5	6-7	8-9	10-18+		
A true friend	Boys	.98	.00	.01	.00	.00	.01	-.291	+
	Girls	.77	.20	.02	.01			-.102	+
Somebody who is often afraid	Boys	.77	.13	.04	.02	.01	.03	.137	+
	Girls	.83	.12	.03	.01	.00	.01	-.004	-
A class president	Boys	.79	.11	.04	.02	.02	.02	-.341	+
	Girls	.86	.09	.02	.01	.01	.01	-.158	+
Somebody who is stuck up	Boys	.71	.19	.05	.03	.01	.01	.192	+
	Girls	.87	.09	.03	.00	.00	.01	-.146	-
A girl to be a teacher of small children	Boys	.99	.01					-.048	+
	Girls	.57	.25	.11	.04	.02	.01	-.436	+
A mean cruel boss	Boys	.65	.21	.09	.02	.01	.02	.063	+
	Girls	.95	.04	.01				-.165	-
A boy to act the part of team captain	Boys	.70	.14	.05	.04	.05		-.293	+
	Girls	.99	.01					-.168	+
A mean bossy sister	Boys	.99	.00	.00	.00	.01		.062	+
	Girls	.57	.25	.10	.05	.01	.02	-.226	-
Someone who is smart and knows the answer	Boys	.81	.09	.04	.02	.02	.02	-.224	+
	Girls	.86	.07	.03	.02	.01	.01	-.266	+
A person who often gets angry over nothing	Boys	.74	.14	.06	.02	.01	.03	.134	+
	Girls	.87	.10	.02	.00	.00	.01	.030	+
Someone who is jolly	Boys	.78	.17	.03	.01	.01		-.078	+
	Girls	.74	.19	.06	.00	.01		-.217	+
A bully who picks on smaller children	Boys	.67	.17	.06	.03	.02	.05	.158	+
	Girls	.98	.01	.01				-.045	-
Someone who is liked by everybody	Boys	.97	.00	.03				-.267	+
	Girls	.74	.19	.03	.02	.01	.01	-.352	+
A very lazy person	Boys	.68	.19	.06	.03	.02	.02	.310	+
	Girls	.91	.08	.01				.137	+

For proportions N = 619 boys, N = 562 girls
For correlations between clinical criterion and item score N = 95 boys, N = 55 girls.
+ = distribution in expected direction
- = distribution not in expected direction

TABLE XXXIX - cont.

Item Someone who could play the part of:	Sex	Proportion of Pupils With Each Frequency of Peer Selection						r for Project Sample With Clinical Criter.	**
		0-1	2-3	4-5	6-7	8-9	10-18+		
15. A very fair person	Boys	.72	.22	.04	.01	.01		-.156	+
	Girls	.80	.18	.01	.01			-.328	+
16. A nice pest--someone who often gets in trouble	Boys	.67	.22	.06	.03	.00	.02	.122	+
	Girls	.88	.09	.02	.01			-.245	-
17. Someone else beside yourself who could direct the play	Boys	.75	.18	.05	.01	.00	.01	-.206	+
	Girls	.79	.18	.02	.00	.01		-.213	+
18. A small child who is always falling down and getting hurt	Boys	.81	.11	.03	.02	.01	.02	.070	+
	Girls	.81	.12	.04	.01	.01	.01	.023	+
19. A school nurse or doctor	Boys	.87	.11	.01	.01			-.165	+
	Girls	.64	.27	.07	.01	.01		-.271	+
20. Someone who seems always to be late for school	Boys	.83	.09	.03	.01	.01	.03	.009	+
	Girls	.92	.04	.01	.01	.00	.02	.115	+

** + = distribution in expected direction
- + distribution not in expected direction

be found for the even numbered items and the criterion score since these traits are designed to be indicative of maladaptive behavior.

Since the item correlations do not yield validity coefficients which are high enough to make a firm statement about the value of the item for predicting the clinical criterion, other indices of the item validity are needed. One procedure is to determine whether the distributions of the items are in accord with the design of the ratings. In other words, are the correlations for the even numbered items with the criterion positive and are the correlations for the odd number items with the criterion negative? The last two columns of both Table XXXVIII and XXXIX provide this information. One can see from inspection that of the twenty items, the distribution is in the expected direction for eighteen of them in the case of second grade boys and for all twenty items in the case of fifth grade boys. A sign test yields highly significant results in both samples of boys. For second grade girls, eight of the twenty items are not in the expected direction and the distribution for one of them yields no specific direction when high and low clinical criterion scores are considered. Six of the twenty items on the *Class Play* do not yield distributions in the expected direction for fifth grade girls either. From this comparison the distribution of the items on both peer ratings for boys is what has been predicted, but is not entirely consistent for girls. In the case of second and fifth grade girls general peer rating items do not select the same types of girls as the clinicians select in their independent ratings of school adjustment status. Prior to this section the *Behavior Rating of Pupils* was evaluated and correlations were presented which showed the degree to which items on the teacher rating were capable of predicting clinical judgment. The reader will recall that the item, "This pupil gets into fights or quarrels with other pupils" did not significantly predict the clinical criterion for second and fifth grade girls. When teachers rate a girl as having a quarrelsome attitude, this behavior is either not perceived or not rated negatively by the clinician. Therefore, the fact that the item distributions do not agree with the distribution of the criterion for girls may be due to differences in clinician and peer perceptions of what constitutes negative behavior. In addition, it must be remembered that while the items in question may not be valid in predicting the clinical criterion, they may not be valid either for predicting other criteria of emotional handicaps and learning and behavior problems. Without further study of a variety of types of behavior in the sample of girls, the question as to the validity of the item cannot be answered conclusively.

Table XL lists the means and standard deviations for thetotal number of selections, the number of negative selections (even numbered items) and the percent of negative selections. The retest reliabilities found in a previous research study (75) are listed here as an estimate of the reliability of the instruments.

Section II of the *Class Play* which presents thirty different quartets of four parts (two negative and two positive from the list of twenty) provides an opportunity for the student to select himself for any of the roles for which he has just selected his peers. It is included in the peer rating instrument as a self rating and should be discussed under that group of ratings rather than in this section of the report; however, it is included here since it is an integral part of the *Class Play*. The means and standard deviations for the number of times pupils select themselves for the negative parts in the thirty items is indicated at the bottom of Table XL.

The correlation of the peer rating summary scores with the clinical criterion can be used to determine the validity of the peer ratings. Table XLI that follows lists these for all summary data on the two tests.

TABLE XL

Distribution of Peer Rating Summary Scores for Class Pictures and Class Play--All Second and Fifth Grade Boys and Girls and Self Rating on Class Play for Fifth Grade

	Group			
	Class Pictures		Class Play	
	Boys	Girls	Boys	Girls
1. Total Number of Selections				
Mean	78.73	17.77	21.77	17.50
Standard Deviation	10.38	10.38	12.71	10.21
Est. Retest Reliability*	.76*		.91*	
2. Number of Negative Selections				
Mean	9.73	8.41	12.29	7.85
Standard Deviation	7.01	8.04	10.81	7.07
Est. Retest Reliability*	.84*		.94*	
3. Percent Negative Selections				
Mean	48.37	43.75	56.00	44.14
Standard Deviation	24.41	24.15	29.00	28.40
4. Section II - Class Play - Number of Negative Self Selections (Fifth Grade Only)				
Mean			9.65	6.11
Standard Deviation			5.44	6.03
N	581	554	619	562

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* Quoted here from previous study in: Lambert, N. M. and Bower, E. M. Technical Report - Process for In-School Screening of Children with Emotional Handicaps Princeton, New Jersey: Educational Testing Service, 1961.

TABLE XLI

Correlation of Summary Scores on Class Pictures (Second Grade) and Class Play (Fifth Grade) With Clinical Criterion

Summary Scores	r* with criterion			
	2nd Grade Girls	2nd Grade Boys	5th Grade Girls	5th Grade Boys
Total number of selections	-.211	-.003	-.418**	-.159
Number of negative selections	-.125	.314**	-.104	.199
Percent negative selections	.054	.438**	.164	.322**
Section II Class Play				
Number of negative selections			-.029	.234**
Percent negative selections			-.045	.318**

The correlation of peer rating summary scores with the clinical criterion is disappointingly low for both groups of girls. In the case of percent negative peer and self selections the validity coefficients for the boys are significantly different from chance. The number of selections does not correlate significantly for the two groups of boys indicating that being selected a large or small number of times by peers is not related to the clinical criterion of school adjustment.

Some idea of the source of the failure of the summary scores for girls to predict the criterion to a significant degree can be found by referring to the correlation of the total number of selections with the criterion. In the case of fifth grade girls this correlation is negative and highly significant. The correlation for second grade girls is in the same direction and approaches the 5% level of significance, but does not reach it. While the peer rating summary score of percent of negative selections is not valid for girls in predicting the criterion, the degree to which a girl is perceived, either positively or negatively, is most related to clinical judgment of poor school adjustment. The means and standard deviations for the summary scores of both peer ratings indicate that girls are perceived by peers as having both desirable and undesirable behavior but the girls with a high degree of negative perception by peers are not necessarily the ones which the clinicians select as having poor school adjustment. This suggests that girls judged by clinicians to have school adjustment problems are class isolates, and pupils with minimal role development in the eyes of the peers. This statement is supported to some degree by the fact that some of the items on the peer ratings which did not have distributions of peer selections in the expected direction are items which describe acting-out behavior, and items which describe, either positively or negatively, pupils interacting with other pupils. These results raise the question of why boys with negative role perception by peers are selected by the clinicians as having poor school adjustment, while girls with negative role perception are not necessarily seen by clinicians as having school difficulties. The answer to this question may provide further clues as to differences in the symptomatology of poorly adjusted boys and girls, and also answer some of the questions frequently raised as to why more boys are referred to the helping professions because of emotional difficulties than girls.

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* N = 75, second grade boys, 74, second grade girls, 95, fifth grade boys and 55, fifth grade girls

** significant at 5% level

The prediction of the clinical criterion by the use of percent of negative selections has been shown to be valid for second and fifth grade boys. While the percent of negative selections does not predict the clinical criterion in the sample of second and fifth grade girls, the degree of perception by peers appears to be significantly related to clinical judgment of poor school adjustment.

Turning for a moment to Section II of the Class Play, the reader can see that both the number of negative self selections and the percent of negative self selections have significant validity coefficients for fifth grade boys. There appears to be no relationship, on the other hand, between fifth grade girls selecting themselves for negative roles and clinical judgment of poor school adjustment. One wonders whether the lack of role perception by peers in the case of the clinically determined school adjustment problems in girls is further compounded by the fact that these same girls have little, if any, self perception of particular negative traits; in fact there seems to be a trend for them to elect themselves fewer times for negative roles when compared to their classmates. Is this denial, lack of realistic self perception, or psychologically a failure to develop self awareness? These and other questions noted previously remain to be answered.

A subsequent table, Table XLVI (page 138) indicates that the correlation between percent negative self selections and the original teacher rating of school adjustment status is positive and significantly different from chance at the 5% level for both fifth grade boys and girls. Such a finding suggests that teacher rating of school adjustment status is more predictive of negative self perception than the clinical criterion of school adjustment. Further evaluation of the differences between clinical and teacher perceptions of maladjusted pupils would appear to be a profitable venture in furthering our understanding of school adjustment problems in second as well as fifth grade pupils.

3. Findings From the Administration of the Self Ratings - Picture Game to Second Grade Pupils and Thinking About Yourself to Fifth Grade

The self ratings designed for use as screening instruments provide a format to determine the degree of dissatisfaction with oneself and the degree of discrepancy between one's perceived ideal vs perceived real self. Specific personality dynamics cannot be inferred from scores on either the Picture Game or Thinking About Yourself. All that can be said about a score on either instrument is that a pupil sees the world and himself in it as a reasonable satisfying place or that he finds himself and his environment wanting. Ambivalence is to be predicted and judged to be typical of a pupil with fairly good adjustment; therefore average scores on the self rating instruments indicate pupils having an acceptable and realistic self perception.

a. The Picture Game

Since this instrument was designed to be used with primary age children who have not yet developed sufficient reading skills to manage a typical test format, pictures depicting a number of neutral life situations were prepared so that a child could respond either positively or negatively to each one. The testing task for the child is to sort the pictures into piles according to whether he perceives the pictures as showing a "sad" or "happy" scene. The score is derived from counting the number of pictures placed in the "happy" side of the box. Previous study of the Picture Game (75) indicates that the selection of a particular picture as "happy" or "sad" does not predict significantly school adjustment status. While pupils with school problems tend to see each card as more often "sad" when compared to their peers, the total score indicating the degree to which the set of pictures is seen as generally "sad" rather than "happy" has been used as the screening measure. Low scores are associated with school adjustment problems; therefore negative correlations of the Picture Game with other screening measures as well as with the clinical criterion would be expected.

1) Normative Data on the Picture Game

Table XLII provides the distribution of scores on the Picture Game for both second grade boys and girls as well as the mean and standard deviation for the entire sample to whom the test was administered. An estimated retest reliability is provided from another source (75) since no time was available in the project to complete a second administration of the instrument.

2) Validity Data on the Picture Game

The correlations of the Picture Game scores for the project samples with the clinical criterion can be found on Table L and LI (pages 143 & 144) for girls and boys. The correlation is significant at the 5% level for boys but it is not different from what could be expected from chance relationships for second grade girls. Table XLVIII (page 141) which presents the intercorrelations of the screening instruments and other data indicates that the relationship between Picture Game scores and teacher and peer ratings are quite significant for boys. The teacher rating is found to be not significantly with IQ scores, for both boys and girls. Table XLVI (page 138) lists the correlation of Picture Game scores with original teacher rating of school adjustment. Again an insiginficant correlation is found for the project sample of girls, and a significant relationship is found between the score for boys and teacher rating of school adjustment.

The Picture Game score appears to have useful validity in predicting the clinical criterion for second grade boys, but no significant relationship was found for the sample of girls. Correlations with other screening and criterion measures indicate that while a significant correlation exists between Picture Game scores and IQ estimates, the validity of the score for girls remains to be evaluated. Until a clearer picture of the differences between teacher and clinician perception of problem pupils has been drawn it will be difficult to determine whether the Picture Game should be dropped from the battery of screening procedures for second grade girls.

b. Thinking About Yourself

The present form of this test is somewhat different from earlier editions referred to in the reference material (12) (14). The revision was prompted by a need to develop an item form which would lend itself more readily to an interpretation of degree of discrepancy between perceived and ideal self. In order to accomplish this the items were carefully worded to avoid any implied value

TABLE XLII

Distribution of Picture Game Scores for Second Grade Boys and Girls, Means, Standard Deviations of Retest Reliabilities

Frequency	Group	
	Girls	Boys
0-5	4	5
6-10	9	17
11-15	35	44
16-20	64	91
21-25	126	157
26-30	157	159
31-35	101	75
36-40	24	12
41-45	12	3
46-50	2	1
N	534	564
Mean	27.92	25.99
Standard Deviation	7.56	7.14
Estimated Retest Reliability*	.65	.75

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* Quoted here from previous study in:
Lambert, N. M. and Bower, E. M. Technical Report - Process for In-School Screening of Children with Emotional Handicaps Princeton, New Jersey: Educational Testing Service, 1961.

statements. Originally the item was presented and the pupil indicated in spaces below the item the degree to which he was like the person described in the item as well as the degree to which he would like to be the person in the item. On the present revision the forty items are presented in two parts. On the first part the pupil indicates the degree to which he would like to be like any of the people in the forty items and on the second part he indicates whether or not he is like any of the people in the items. For this try-out of the revision, the test was scored in such a way as to indicate the direction of the differences, more like or less like, between the perceived and ideal self on each item. A careful review of the item statistics indicated that all of the items were seen as both positive and negative by the students (in agreement with the design of the items) so that a score which accounted for the discrepancy between ideal and real self (an absolute difference) rather than the direction of the difference (an algebraic difference) was selected as the appropriate measure.

1) Normative Date on Thinking About Yourself

Table XLIII and XLIV present the distribution of item scores for fifth grade girls and boys, respectively, for each of the forty items. The proportions were computed on the basis of the administration of the test to the entire fifth grade population in the project. A score of "0" indicates that there is no difference between the way a pupil selects himself for an item and the way he would like to be on that same item. In other words a zero score indicates no difference between perceived and ideal self. Scores of "1", "2" and "3" indicate the degree of discrepancy between perceived and ideal self. A score of three suggests the maximum amount of discrepancy between these two perceptions. Studies of earlier forms of Thinking About Yourself (12) (75) indicated that the performance on individual items of the test did not consistently discriminate between a criterion group of pupils with poor adjustment and a sample of their peers. The total score did discriminate and has subsequently been suggested as the screening score.

The distribution of total scores as well as the means and standard deviations can be found on Table XLV. The parameters for boys and girls are comparable and the distributions are approximately normal in shape. A split half reliability was computed by correlating the score on the first 20 items with the score on the second twenty and found to be .64 for boys and .49 for girls. Since the items were not designed to be homogeneous in content, a split half reliability of such a degree may be found in a test may be highly stable from one test administration to the next but not parallel in the two halves. Previous retest reliabilities on a sample of 70 girls and 81 boys using an earlier form of Thinking About Yourself were found to be .879 for girls and .823 for boys. It is conceivable that retest reliabilities for the present form would be of an equivalent magnitude, but no confirmation of this assumption has been made.

2) Validity Date for Thinking About Yourself

Table LII and LIII (pages 145 & 146) present the correlations between the clinical criterion and TAY scores for fifth grade girls and boys respectively. Table XLIX (page 142) lists the intercorrelations of the screening materials. From these data one can see that a significant relationship exists between Thinking About Yourself scores and the clinical criterion for fifth grade boys, but that the validity for Thinking About Yourself for girls is not established with these data. It is interesting that the correlation of the

TABLE XLIII

Distribution of Item Scores on TAY
Fifth Grade Girls

Item Number	Percent Receiving Item Score			
	0	1	2	3
1	.49	.41	.09	.01
2	.66	.29	.04	.01
3	.66	.16	.07	.11
4	.54	.35	.09	.02
5	.44	.44	.10	.02
6	.57	.34	.07	.02
7	.47	.32	.14	.07
8	.65	.26	.08	.01
9	.53	.36	.09	.02
10	.41	.35	.19	.05
11	.62	.29	.06	.03
12	.27	.28	.30	.15
13	.67	.27	.04	.02
14	.56	.32	.08	.04
15	.22	.25	.26	.27
16	.76	.19	.03	.02
17	.46	.39	.12	.03
18	.70	.24	.05	.01
19	.86	.09	.02	.03
20	.35	.37	.24	.04

Item Number	Percent Receiving Item Score			
	0	1	2	3
21	.60	.34	.05	.01
22	.49	.37	.12	.02
23	.36	.33	.23	.08
24	.29	.33	.24	.14
25	.64	.28	.05	.03
26	.65	.25	.09	.01
27	.34	.37	.24	.05
28	.27	.27	.27	.19
29	.73	.23	.03	.01
30	.20	.42	.28	.10
31	.56	.37	.04	.03
32	.56	.36	.07	.01
33	.55	.31	.11	.03
34	.71	.24	.04	.01
35	.36	.32	.21	.11
36	.57	.30	.12	.01
37	.26	.40	.24	.10
38	.61	.26	.09	.04
39	.60	.31	.07	.02
40	.66	.27	.05	.02

TABLE XLIV

Distribution of Item Scores on TAY
Fifth Grade Boys

Item Number	Percent Receiving Item Score			
	0	1	2	3
1	.47	.37	.12	.04
2	.59	.33	.06	.02
3	.59	.17	.09	.15
4	.57	.35	.06	.02
5	.46	.37	.13	.04
6	.60	.32	.06	.02
7	.45	.31	.15	.09
8	.67	.24	.06	.03
9	.50	.39	.08	.03
10	.43	.37	.14	.06
11	.53	.33	.09	.05
12	.31	.27	.24	.18
13	.65	.28	.03	.04
14	.54	.33	.09	.04
15	.23	.28	.26	.23
16	.66	.25	.05	.04
17	.54	.31	.13	.02
18	.65	.28	.05	.02
19	.74	.15	.06	.05
20	.38	.38	.19	.05
21	.69	.25	.04	.02
22	.43	.36	.15	.06
23	.44	.37	.15	.04
24	.32	.28	.25	.15
25	.57	.32	.08	.03
26	.63	.26	.09	.02
27	.35	.32	.26	.07
28	.30	.31	.22	.17
29	.72	.24	.02	.02
30	.26	.43	.22	.09
31	.55	.35	.07	.03
32	.52	.32	.12	.04
33	.45	.40	.11	.04
34	.70	.24	.05	.01
35	.40	.29	.21	.10
36	.52	.34	.12	.02
37	.36	.35	.20	.09
38	.50	.30	.14	.06
39	.62	.26	.08	.04
40	.65	.26	.06	.03

TABLE XLV

Distribution of TAY Scores for Fifth Grade Boys and Girls, Means, Standard Deviations and Split Half Reliability

Total Score Distribution	Group	
	f-Boys	f-Girls
0-4	9	10
5-9	14	13
10-14	42	29
15-19	72	67
20-24	111	80
25-29	88	112
30-34	84	102
35-39	79	59
40-44	40	27
45-49	27	30
50-54	14	7
N	592	542
Mean	28.64	28.37
Standard Deviation	10.23	10.39
Split Half Reliability	.636	.486

social worker qualitative judgments is the highest among the group of clinical qualitative judgments for both sexes. Also the correlation between *Thinking About Yourself* and Section II of *Class Play* for girls is higher than that for boys (Table XLIX). Even though the teacher rating correlates significantly with Section II **of the** *Class Play* for both boys and girls, the same does not hold for *Thinking About Yourself* where there is an insignificant relationship when teacher and peer ratings are compared to *Thinking About Yourself* scores for girls.

The validity estimates of the self ratings for both second and fifth grade boys while low are significant at the 5% level. The same does not hold for the two project samples of girls. In the case of the girls, the degree to which agreement exists between teacher and clinical perception of school adjustment problems is questioned. Further exploration of these differences might shed light on the low correlations between self ratings of girls and outside criteria of school adjustment status. For the present we can say only that while girls obtain equally negative scores on both instruments, the meaning of these scores in predicting school adjustment status is in question. Further study of the self rating instruments should be made by comparing case material of girls and boys with comparable negative scores to see if some bias exists in the criterion which might account for the insignificant validity estimates. Such a comparison might also be of value in determining whether or not girls are able to rate themselves as accurately as boys are.

Findings From a Study of the Screening Battery as a Whole

The subsequent comparisons which are discussed use only the project sample of pupils. One can compare means and standard deviations for any scores on the screening battery in order to determine the degree to which the project sample deviated from the norm group. Since the sample was selected originally to contain a slightly larger percentage of pupils with school adjustment problems (as perceived by a previous teacher) mean scores would be expected to be in the direction of more negative ratings when discrepancies are discovered.

a. Relationship Between Screening Battery and Original Teacher Rating of School Adjustment

The correlations of scores on the screening battery with the original teacher rating of school adjustment status are presented in Table XLVI. Grades and number of unsatisfactory marks in citizenship on the report card, estimated WISC IQ's obtained from testing by the clinical psychologist in addition to scores on the screening materials can be found. Those relationships which did not reach the 5% level of significance are noted. Of interest is the comparison between the original teacher ratings of school adjustment and the ratings made by the current teacher on the *Behavior Rating of Pupils*. The correlations are all positive except for item "E". Item "E" correlated negatively with clinical criterion of school adjustment and was discussed previously. While the total teacher rating score is substantially related to the original teacher rating in all samples, several insignificant correlations are noted in the sample of fifth grade girls. Again one must question the source of this discrepancy. Items "A", "D" and "F" were found to be insignificantly correlated with the clinical creterion (Table XXXVII, page 121) but items "C" and "E" in addition do not reach the 5% level when correlated with the original teacher rating.

The relationship between original teacher rating and WISC IQ scores is also interesting. In all cases the lower the IQ score the more negative or higher

TABLE XLVI

Correlation of Original Teacher Rating and School Adjustment with Selected Pupil Data On Scores on Screening Battery

	GROUP			
	Second Grade Girls	Second Grade Boys	Fifth Grade Girls	Fifth Grade Boys
SCHOOL REPORT CARD				
1. Reading Grade	-.009*	-.435	-.095*	-.174*
2. Arithmetic Grade	-.015*	-.332	-.233*	-.238
3. Language Grade	.118*	-.460	-.093*	-.130*
4. Social Studies Grade	.118*	-.297	-.267*	-.262
5. Number of Unsatisfactory Marks	.241	.381	.147*	.306
WISC. IQs (Administered individually)				
Verbal IQ	-.356	-.308	-.352	-.089*
Performance IQ	-.238	-.282	-.143*	-.084*
Full Scale IQ	-.338	-.337	-.292	-.106*
SCREENING BATTERY				
Teacher Rating:				
A. This pupil gets into fights or quarrels with other pupils.	.295	.314	.062*	.461
B. This pupil has to be coaxed or forced to work with others.	.332	.229	.339	.148*
C. This pupil has difficulty learning.	.563	.398	.274*	.389
D. This pupil makes unusual or inappropriate responses during school.	.526	.445	.234*	.492
E. This pupil works extremely hard in learning school subjects.	-.314	-.340	-.189*	-.389
F. This pupil behaves in ways which are dangerous to self or others.	.334	.378	.298	.451
G. This pupil is unhappy or depressed	.466	.437	.500	.337
H. This pupil becomes upset or sick often, especially when faced with a difficult school problem.	.382	.311	.245*	.396
Total of all teacher ratings	.539	.507	.466	.536
Peer Rating: % negative selections on Class Pictures (second grade) on Class Play (fifth grade)	.310	.317	.089*	.479
Self Rating: Picture Game (second grade) or Class Play self (fifth grade)	-.146*	-.235	.290	.349

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* Not significant at the 5% level.

the teacher rating with the exception of fifth grade boys. IQ score has been noted as being related to school mental health criteria, but heretofore little has been said about differences between boys and girls and such a relationship.

Significant correlations are found in the four samples between peer rating, self rating and original teacher rating of school adjustment with the exception of the peer ratings for fifth grade girls and the self rating for second grade girls. Correlations between original teacher rating and Thinking About Yourself were not available for fifth grade boys and girls.

b. Means and Standard Deviations of the Screening Instruments and Selected Pupil Data

Table XLVII presents the means and standard deviations for the project samples on the screening materials, the WISC IQ's and the Index of Social Status Characteristics. The latter measures were taken from the clinical records of the psychologist and social worker. Since additional accuracy of prediction might be accomplished by adding measures of intelligence and socio-economic status to the screening materials, these scores are included here and will be evaluated subsequently along with the screening materials. A significant relationship appears to exist between original teacher rating and IQ; therefore one would expect that IQ might correlate significantly with the clinical criterion. Socio-economic status which has been the object of much mental health research should also have predictive value. Other predictors of the clinical criterion might be considered; however, for this study the individual IQ score and the Index of Social Status Characteristics were selected since they are estimates of two potential sources available data which could be included in a screening program.

c. Intercorrelations of the Screening Instruments and Selected Predictive Data

Tables XLVIII and XLIX present the intercorrelations of the screening materials for second and fifth grades respectively. In all samples the highest correlations are found between teacher and peer ratings, teacher and self ratings next and then peer and self ratings when the screening battery is compared. In spite of previously discussed differences in the ability of the screening materials to predict the clinical criterion the relationship of ratings within the screening battery appears to be fairly consistent from sample to sample with the exception of the self rating scores. The WISC IQ scores and the Index of Social Status Characteristics also appear to have meaningful relationships to the screening material.

d. Correlations of Various Predictors With Clinical Criteria

Two types of clinical summary scores were discussed previously. One was the sum of all the qualitative judgments made by the clinical group and the other was the overall judgment of school adjustment status. The means and standard deviations for these scores were presented on Table XVIII and XIX (pages 83 & 84). Even though the clinical criterion selected for the validation of the screening process was the sum of the three final judgments of school adjustment status, the correlations of screening materials, intellegence, achievement and socio-economic status with these other criteria of school adjustment may provide some hints as to differences in perception of pupils by each clinical discipline.

Table L for second grade girls, Table LI for second grade boys, Table LII for fifth grade girls and Table LIII for fifth grade boys provide useful clues to

TABLE XLVII

Means and Standard Deviations of Screening Instruments, WISC Scores and Index of Social Status Characteristics For Project Pupils

SCREENING BATTERY	2nd Grade Girls		2nd Grade Boys		Fifth Grade Girls		Fifth Grade Boys	
	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.
Teacher Rating								
A. This pupil gets into fights or quarrels with other pupils	3.51	1.44	4.37	1.50	3.52	1.48	4.44	1.61
B. This pupil has to be coaxed or forced to work with others	3.92	1.43	4.06	1.57	4.37	1.33	4.00	1.54
C. This pupil has difficulty learning	3.78	1.44	4.62	1.48	4.14	1.49	4.20	1.71
D. This pupil makes unusual or inappropriate responses during school	3.57	1.43	4.25	1.47	3.67	1.48	4.61	1.68
E. This pupil works extremely hard in learning school subjects	4.15	1.41	3.31	1.57	4.09	1.62	3.48	1.57
F. This pupil behaves in ways which are dangerous to self and others	3.56	1.51	4.51	1.41	3.62	1.41	4.68	1.62
G. This pupil is unhappy or depressed	3.90	1.63	4.45	1.62	4.16	1.49	4.30	1.47
H. This pupil becomes upset or sick often, especially when faced with a difficult school problem	4.04	1.77	4.41	1.51	4.27	1.49	4.38	1.44
Total teacher rating	30.33	7.23	33.83	6.71	31.71	5.23	33.99	6.50
Peer Rating								
Total Number of Selections	18.57	11.67	16.10	8.00	16.05	9.46	21.11	13.22
Total Negative Selections	8.96	9.69	7.67	5.92	8.00	8.08	12.00	10.10
Percent Negative Selections	46.47	23.42	48.84	23.47	48.23	30.56	56.78	28.86
Self Rating								
Picture Game	30.68	8.57	27.33	7.09				
Total Negative Selections - Part II Class Play					6.58	6.24	8.15	6.42
Thinking About Yourself					28.29	9.20	26.89	11.00
WISC est. Verbal IQ	100.08	14.15	102.08	17.15	101.71	14.29	105.39	14.29
WISC est. Performance IQ	107.88	14.49	105.85	16.24	105.73	17.44	108.23	18.10
WISC est Full Scale IQ	104.09	13.97	104.30	15.98	104.09	15.18	107.37	15.22
Index Social Status Characteristics	48.86	11.55	50.75	12.26	46.33	11.30	45.09	11.88

TABLE XLVIII

Intercorrelations of Screening Instruments, IQ, Reading Achievement, Arithmetic Achievement, and Index of Social Status Characteristics - Second Grade

	1	2	3	4	5	6	7	8	9	10
1. Teacher Rating (Behavior Rating of Pupils)		.500	-.110	-.298	-.276	-.147	-.169	-.147	-.169	.311
2. Peer Rating (Class Pictures)	.569		.014	-.123	-.097	-.254	-.225	-.254	-.225	.207
3. Self Rating (Picture Game)	-.362	-.392		.290	.310	.209	.097	.209	.097	-.189
4. IQ (Est. WISC)	-.382	-.321	.345		.535	.202	.124	.046	-.046	.446
5. Group IQ	-.214	-.234	.254	.516		.293	.198	.007	.059	-.460
6. Reading Achievement	-.038	-.165	.083	.126	.189		.703	.105	.102	--
7. Arithmetic Achievement	-.066	.003	.179	.122	.147	.012		.022	.008	--
8. Reading Grade	-.452	-.452	.386	.363	.312	.211	.003		.862	-.107
9. Arithmetic Grade	-.435	-.465	.245	.419	.385	.330	-.027	.703		-.039
10. Index of Social Status Characteristics (ISS)	.215	.205	-.294	-.352	--	--	--	-.319	-.321	

Note: Entries above the diagonal are for girls; those below the diagonal are for boys.

TABLE XLIX

Intercorrelations of Screening Instruments, IQ, Reading Achievement, Arithmetic Achievement, and Index of Social Status Characteristics - Fifth Grade

	1	2	3	4	5	6	7	8	9	10	11
1. Teacher Rating (Behavior Rating of Pupils)		.489	.269	.019	-.156	-.013	-.213	-.287	-.213	-.287	.151
2. Peer Rating (Section I, Class Play)	.628		.032	-.029	.080	.087	.095	-.185	.095	-.185	-.009
3. Self Rating (Section II, Class Play)	.366	.010		.371	-.182	-.152	.014	-.050	.014	-.050	.029
4. Self Rating (Thinking about yourself)	.266	.213	.200		-.021	--	--	--	--	--	.310
5. IQ (Est. WISC)	-.236	-.127	-.273	.031		.545	.481	.321	.269	.286	-.398
6. Group IQ	-.303	-.163	-.239	--	.578		.371	-.008	.415	.265	--
7. Reading Achievement	-.185	-.085	-.130	--	.363	.501		.680	.425	.293	--
8. Arithmetic Achievement	-.113	-.085	-.024	--	.326	.204	.549		.084	.206	--
9. Reading Grade	-.296	-.149	-.040	--	.168	.382	.265	.124		.588	--
10. Arithmetic Grade	-.455	-.220	-.094	--	.200	.256	.134	.139	.707		--
11. Index of Social Status Characteristics (ISS)	.127	.033	.200	-.068	-.446	--	--	--	--	--	

Note: Entries above the diagonal are for girls; those below the diagonal are for boys.

TABLE L

Correlations Between Scores on Screening Battery, Clinical Judgment of School Adjustment, Socio-Economic Status, WISC IQ and School Achievement for Second Grade Girls

	Teacher Rating	Peer Rating	Self Rating	Group IQ	WISC IQ	Reading achievement	Arith. achievement	Reading Grade	Arith. grade	Father's occupation	ISS**
1. Sum of Social Workers' qualitative judgments	.471	.298	-.133*		-.374	-.094*	-.141*				
2. Over-all Social Workers' judgment of school adjustment	.368	.146*	-.026*		-.374	-.024*	-.092*				
3. Sum of Psychologists' qualitative judgments	.241	.002*	-.112*		-.573	.014*	-.043*				
4. Over-all Psychologists' judgment of school adjustment	.168*	.032*	-.073*		-.370	-.160*	-.214*				
5. Sum of Psychiatrists' qualitative judgments	.205*	-.068*	.091*		-.227	.074*	.020*				
6. Over-all Psychiatrists' judgment of school adjustment	.250	-.029*	-.033*		-.309	-.021*	-.066*				
7. Sum of all qualitative judgments	.372	.081*	-.070*	-.549	-.542			-.004*	-.066*	.167*	.392
8. Sum of over-all clinical judgments of school adjustment status	.308	.054*	-.052*	-.451	-.406			-.086*	-.152*	.089*	.311

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*Not significant at the 5% level

**Index of Social Status Characteristics

TABLE LI

Correlations Between Scores on Screening Battery, Clinical Judgment of School Adjustment, Socio-Economic Status, WISC IQ and School Achievement for Second Grade Boys

	Teacher Rating	Peer Rating	Self Rating	Group IQ	WISC IQ	Reading achievement	Arith. achievement	Reading Grade	Arith. grade	Father's occupation	ISS**
1. Sum of Social Workers' qualitative judgments	.316	.351	-.265		-.383	-.245	-.382				
2. Over-all Social Workers' judgment of School adjustment	.310	.349	-.329		-.450	-.372	-.455				
3. Sum of Psychologists' qualitative judgments	.419	.372	-.303		-.643	-.445	-.410				
4. Over-all Psychologists' judgment of school adjustment	.434	.447	-.244		-.519	-.500	-.458				
5. Sum of Psychiatrists' qualitative judgments	.231	.169*	-.031*		-.101*	-.289	-.232				
6. Over-all Psychiatrists' judgment of school adjustment	.350	.347	-.277		-.374	-.480	-.464				
7. Sum of all qualitative judgments	.455	.421	-.287	-.344	-.582			-.479	-.472	.261	.323
8. Sum of over-all clinical judgments of school adjustment status	.425	.438	-.326	-.392	-.531			-.548	-.533	.281	.318

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*Not significant at the 5% level

**Index of Social Status Characteristics

TABLE LII

Correlations Between Scores on Screening Battery, Clinical Judgment of School Adjustment, Socio-Economic Status, WISC IQ and School Achievement for Fifth Grade Girls

	Teacher Rating	Peer Rating	Self Rating CP	Self Rating TAY**	Group IQ	WISC IQ	Reading achievement	Arith. achievement	Reading Grade	Arith. grade	Father's occupation	ISS***
1. Sum of Social Workers' qualitative judgments	.168*	.042*	.121*	.312		-.480	-.178*	-.215*				
2. Over-all Social Workers' judgment of school adjustment	.371	.135*	-.134*	.213*		-.505	-.233*	-.389				
3. Sum of Psychologists' qualitative judgments	.372	.029*	.073*	.046*		-.798	-.193*	-.224*				
4. Over-all Psychologists' judgment of school adjustment	.418	.066*	.066*	-.101*		-.721	-.178*	-.327				
5. Sum of Psychiatrists' qualitative judgments	.325	.136*	-.121*	.034*		-.170*	-.425	-.307				
6. Over-all Psychiatrists' judgment of School adjustment	.429	.125*	-.009*	.094*		-.583	-.418	-.341				
7. Sum of all qualitative judgments	.448	.106*	.106*	.106*	-.388	-.739			-.381	-.354	.300	.380
8. Sum of over-all clinical judgments of school adjustment status	.511	.164*	.164*	.087*	-.367	-.742			-.343	-.428	.299	.428

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* Not significant at the 5% level

**No. of neg. selections on Section II Class Play and score on Thinking About Yourself

***Index of Social Status Characteristics

TABLE LIII

Correlations Between Scores on Screening Battery, Clinical Judgment of School Adjustment, Socio-Economic Status, WISC IQ and School Achievement for Fifth Grade Boys

	Teacher Rating	Peer Rating	Self Rating		Group IQ	WISC IQ	Reading Achieve-ment	Arith. Achieve-ment	Reading Grade	Arith. Grade	Father's Occupa-tion	ISS***
			CP	TAY**								
1. Sum of Social Workers' qualitative judgments	.250	.229	.024*	.132*		-.265	-.086*	-.208				
2. Over-all Social Workers' judgment of school adjustment	.420	.264	.136*	.239		-.350	-.249	-.360				
3. Sum of Psychologists' qualitative judgments	.356	.275	.266	.032*		-.602	-.241	-.300				
4. Over-all Psychologists' judgment of school adjustment	.329	.251	.162*	.022*		-.326	-.192*	-.267				
5. Sum of Psychiatrists' qualitative judgments	.373	.187*	.236	.169*		-.209	-.255	-.280				
6. Over-all Psychiatrists' judgment of school adjustment	.431	.329	.330	.295		-.353	-.220	-.263				
7. Sum of all qualitative judgments	.439	.322	.280	.098*	-.499	-.585			-.268	-.360	.172*	.289
8. Sum of over-all clinical judgments of school adjustment status	.530	.357	.318	.271	-.423	-.377			-.258	-.383	-.077*	.100*

* Not significant at the 5% level
** No. of neg. selections on Section II Class Play and Score on Thinking About Yourself
*** Index of Social Status Characteristics

explaining the lack of validity in some of the screening materials when they are compared with the clinical criterion. For both samples of boys teacher, peer and self ratings have significant validity coefficients for consideration in a screening program is one wishes to predict subsequent clinical judgment of school adjustment status using the clinical criterion established in this project. Estimates of WISC IQ scores are significantly related to the clinical criterion in both samples also. Socio-economic status as measured by the index of social status characteristics in the sample of second grade boys is significantly correlated with the clinical criterion, but is not significantly correlated with it in the sample of fifth grade·boys. While neither the available group IQ score from the cumulative record, nor the classification of father's occupation (according to the first digit in the occupation code in the Dictionary of Occupational Titles (37) yield as high correlations, they, too are related in a similar manner to the clinical criterion. When similar data for girls are compared, the WISC IQ socres and indices of socio-economic status maintain their significant correlations with the clinical criterion. The surprisingly high correlation between the clinical criterion and the WISC IQ for fifth grade girls along with a correlation of .428 (highest of all four samples) between the clinical criterion and index of social status characteristics indicates that clinicians are evidently responding to behavior possibly related to the two variables in their ratings for fifth grade girls more than they are in other samples. A point has been made of the fact that in the sample of fifth grade girls, the three girls with consensus clinical judgment of school adjustment status described in Chapter VI had extremely low WISC IQ scores. The scores were so low, in fact, that the question of mental retardation should be raised. Nevertheless these pupils were all in regular classes and apparently functioning well enough to keep up with their peers. No answer can be given to the question which logically follows as to why IQ and socio-economic status appears to be so important in the samples of girls (and not so in the sample of boys) with peer and self ratings providing minimal predictive validity. On the other hand the correlation of WISC IQ with the screening materials is notably greater for boys than for girls. Evidently WISC IQ's of boys are more related to school ratings of adjustment (teacher, peer and self) while WISC IQ's of girls are more predictive of clinical judgment of school adjustment. Further explanation of these differences might account for the higher incidence of boys than girls referred to school guidance offices.

e. Multiple Prediction of the Clinical Criterion With Various Patterns of Screening Scores, est WISC IQ and Socio-Economic Status

The clinical criterion, a sum of three final clinical judgments made for each pupil of his school adjustment status, was selected because the intercorrelations of the three separate ratings of school adjustment were of comparable magnitude for all samples. No effort was made to weight any of the individual clinical ratings of school adjustment status even though a weighting procedure if developed might yield a better criterion measure. The clinical criterion runs from ratings of best school adjustment (low scores) to poorest school adjustment (high scores). This project was designed to determine whether the screening instruments can be combined into an Index of Alienation or Relatability which would indicate the degree to which a pupil would be free from or handicapped by emotional difficulties. The clinical criterion is one such index. A multiple regression procedure which combines the screening materials into a weighted sum with the best prediction of the clinical criterion provides a method for developing an Index of Alienation or Relatability with the use of easily available material from school classrooms. The lower the weighted screening score the more the pupil can be expected to be free from handicapping emotional difficulties and school adjustment problems. In other words he would be expected to relate well for his age, to his group and life situation and the higher the sum of the weighted screening instruments the more handicapped or alienated the pupil.

If one accepts the clinical criterion distribution as one Index of Alienation - Relatability in terms of school adjustment, the degree to which the weighted sum of the predictor screening variables predicts the clinical criterion indicates the validity of the screening battery as well as the degree to which the weighted sum can be used as the Index of Relatability of Alienation.

If the clinicians were asked to predict family adjustment, relationship to peers, delinquency or health problems, the criterion score would be different from the one in this project, even though the basic clinical data might remain the same. The weighted sum of the scores on the screening battery, if it were found to be predictive of another criterion would, therefore, quite possibly have different weights for the ratings in the battery. It is important to keep in mind what the screening scores are predicting in this multiple regression problem. The clinicians were asked to make a judgment about the degree to which the pupils they saw would have difficulties in school. They used comparable criteria, developed in the project, as to what constituted good and poor school adjustment status. These criteria can be found in the Appendix and should be consulted when one tries to attach meaning to the prediction problem which is being discussed. When the degree to which pupils with ratings indicative of school adjustment problems are found to become delinquent, drop out of school, be referred for psychological help, have school achievement and school adjustment difficulties in later school years, have difficulties in getting or keeping jobs, or who become ineffective parents, then the usefulness of the clinical criterion or the multiple regression equation in predicting these mental health problems can be determined. For the present, Lambert (74) has shown that pupils who are judged to have school difficulties in the elementary years by clinicians as well as school staff members are the ones who comprise the major proportion of the delinquent population, the accident and violation prone automobile drivers, the school drop outs, and the discipline problems in high school as well as the ones with poor grades and minimal opportunities for a reasonalby satisfying adulthood. Such data implies that the pupils in this project will also follow in the same paths, however, follow-up studies will be necessary before such an assumption can be confirmed.

For the second grade sample two multiple regression screening batteries were used. The first contained only the three screening ratings. The second includes the three screening ratings as well as the est. WISC IQ score and the Index of Social Status Characteristics. The regression weights which were computed for the predictors in each battery for the screening scores, WISC IQ score and Index of Social Status Characteristics in order to achieve the best prediction of the clinical criterion. Multiple R's for the batteries are noted at the bottom of Table LIV. The poorest prediction is for second grade girls using only the three screening ratings. This prediction is improved when IQ score and socio-economic status are included in the battery. The improvement of prediction with the addition of the intelligence and socio-economic status predictors was to be expected from the fact that both of these measures were substantially correlated with the clinical criterion for the sample of second grade girls while not correlating as well with the screening materials. The inclusion of these addition measures in the battery for boys also improves the multiple prediction. In actual practice one would find it difficult if not impossible to obtain a WISC score on all of the pupils who were to be screened. Group IQ scores which are also substantially correlated with the criterion could have been substituted in

TABLE LIV

Regression Weights for Multiple Prediction of Clinical Criterion of School Adjustment Second Grade Boys and Girls

Predictors	Prediction Batteries			
	Boys		Girls	
	Battery 1	Battery 2	Battery 1	Battery 2
1. Teacher Rating Behavior Rating of Pupils	4.4	2.9	5.9	4.7
2. Peer Rating % Negative Peer Selection, Section I Class Play	1.5	1.5	-6.7	-0.8
3. Self Rating Picture Game	-2.9	-1.1	-0.1	1.5
4. Intelligence est. WISC IQ		-3.7		-3.0
5. Socio-Economic Status Index of Social Status Characteristics		1.5		1.6
R	.51	.62	.49	.33

this case; however, the fact that the available group IQ test scores might have been derived from a variety of tests given at a variety of times to the project sample made the use of the available group IQ score questionable. An estimate of socio-economic status could be made by using a code for father's occupation which provides an ordinal scale ranking of the occupation according to socio-economic status. One such scale might be the first digit in the Dictionary of Occupational Titles occupational code and was used in this project. Others are possible and should be explored. In any case the inclusion of a measure of intelligence and socio-economic status appears to be a useful method of improving the prediction of the clinical criterion in a screening process.

The multiple regression screening batteries for fifth grade pupils are presented on Table LV. Here one can note somewhat better prediction in both cases with the really substantial multiple R in the case of the girls. An additional screening battery is included in this set of data since the intercorrelations for the fifth grade girls contained low correlations of the screening materials with the criterion, but fairly high correlations of the est. WISC IQ and Index of Social Status Characteristics with the criterion. One can see from the weights assigned to each of the predictors that the criterion score must be biased in favor of IQ and socio-economic status for fifth grade girls. This tells us something about the characteristics of the girls which the clinicians selected as having the poorest school adjustment. In the discussion of the validity of the *Class Play* in predicting the criterion, the fact that the number of selections by peers correlated highest with the criterion for fifth grade girls, while the percent of negative selections had a very low, probably only chance correlation with the criterion. The comment was made that the girls the clinicians selected might be characterized as classroom isolates, or girls who do not relate to classmates or who have minimal role development in a group setting. In addition to this fact, it now appears that in the cases of girls judged to be poorly adjusted in school by the clinicians the minimal interaction with peers is compounded by low intelligence and low socio-economic status. In spite of the fact that the basic screening battery of teacher, peer and self rating predicts less well than batteries which include IQ and socio-economic status, it is still possible to locate a substantial proportion of fifth grade girls with school difficulties by using an appropriately weighted screening battery and to improve selection with an adequate measure of intelligence and socio-economic status.

The multiple regression procedure has established a number of predictive equations which can be used to predict the clinical criterion in each of the project samples. To the degree that the clinical criterion is comparable to an Index of Alienation or Relatability, the regression equations can also be considered as a measurement of that index to the extent that they correlate with the clinical criterion.

While a multiple cut-off procedure for combining the screening materials does not yield a regression equation which can be then used as an Index or Alienation or Relatability, a cut-off procedure needs to be explored in terms of its effectiveness in screening pupils who would subsequently have high criterion scores.

f. Use of the Screening Instruments in a Multiple Cut-Off Procedure

The *Manual* (20) for the *in-School Process for screening Emotionally Handicapped Pupils* suggests two steps in the screening process. First the principal of the school asks the teachers to nominate pupils in their classrooms who might be characterized by any particular school difficulty. This procedure is similar to

TABLE LV

Regression Weights for Multiple Prediction of Clinical Criterion of School Adjustment - Fifth Grade Boys and Girls

	Prediction Batteries					
	Boys			Girls		
	Battery 1	Battery 2	Battery 3	Battery 1	Battery 2	Battery 3
1. Teacher Rating Behavior Rating of Pupils	7.2	6.5	7.2	1.5	4.0	2.7
2. Peer Rating % Negative Peer Selections, Section I Class Play	0.1	0.1		0.1	0.1	
3. Self Rating Thinking About Yourself	1.0			0.1		
4. Self Rating % Negative Self Selections Section II Class Play		0.3			-0.6	
5. Intelligence est. WISC IQ		-2.0	-2.1		-2.2	-1.5
6. Socio-Economic Status Index of Social Status Characteristics		-0.9	-0.9		0.4	0.4
R	.55	.60	.60	.53	.89	.85

the one used in this project which asked for principal and teacher nominations prior to the administration of the screening materials. After collecting the nominations, the principal then instructs the teachers on procedures to be used in administering and scoring the screening instruments. The administration of the screening process then takes place. After administering and scoring the teacher, peer and self ratings, the teacher lists the names of the pupils with the five highest, (most negative) teacher ratings, peer ratings and self ratings in her class. The only exception to this rule is that she should select the five lowest scores on the Picture Game for second graders. Then pupils with two or more such negative scores are screened. When a pupil who has been previously nominated receives borderline scores on one or more of the screening instruments, the teacher is instructed to make note of this fact and list them accordingly as belonging to the screened group. Previous studies (75) have indicated that such a procedure selects a variety of pupil difficulties, but these studies have not been related to a completely independent criterion of school adjustment such as the one used in this project.

In order to reproduce the recommended screening procedure, a multiple cut-off method, the means and standard deviations of the norm group were used to provide cut-off scores. Any score on a screening instrument which was more than one standard deviation above the mean was noted. Different cut-offs for each sex and grade sample were therefore necessary. Scores more than one standard deviationbelow the mean on the Picture Game were selected since this distribution runs in the reverse direction from the others. Whether a pupil was nominated prior to the screening phase was also noted. From these lists various groups of pupils were selected. Those pupils who received cut-off scores on teacher, peer and self ratings (TPS) comprise one group. Other groups were those with higher than cut-off scores on teacher and peer ratings (TP) teacher and self ratings (TS) and peer and self ratings (PS). Those pupils with one cut-off score in the cut-off range, with one or more scores in a borderline area were also noted. A score was considered borderline when it was only one or two raw score points from the cut-off. In addition the group of pupils who had been nominated and who obtained one or more screening scores either in the cut-off or borderline range was also noted. The pupils remaining were those who had only one of the screening scores in the cut-off range and who did not receive any prior nomination by teacher or principal. Finally the criterion score for each of these pupils was recorded and the groups thus identified were distributed in a table according to the criterion score. The distribution of the criterion in the project sample was also noted. These tables are LVI, LVII, LVIII and LVIX for second grade girls and boys and fifth grade girls and boys respectively.

Rather than deal with each sample separately, certain general statements can be made about the entire group. Thirty three pupils out of approximately 300 were selected screening scores in the cut-off range and some pattern of TPS, TP, TS or PS. All of the criterion scores for this group were above the mean criterion score for that sample with pupils with the exception of one pupil whose criterion score was at the mean. When pupils with borderline scores or nominations and one screening score in the cut-off range are considered, 36 pupils are added to the list screened. Twenty one of these have scores above the mean criterion score, four of them have scores at the mean and the criterion scores for the remaining eleven are below the mean. Using only scores in the cut-off range, approximately 10 percent of the population is screened with only one pupil at the mean of the criterion and the remainder with above average criterion scores. With the use of the scores in the cut-off range, borderline scores and those with nominations as indicated previously, twenty two percent of the population

TABLE LVI

Comparison of Clinical Criterion With the Use of Various Patterns of Cut-Off on Screening Materials - Second Grade Girls

	Clinical Criterion Score	Distribution of Clinical Criterion in Project Sample	Frequency of Project Pupils With Combinations of Screening Patterns*								
			TPS	TP	PS	TS	1 qualified +1 borderline rating	nominated +1 or more qualified or borderline rating	T only	P only	S only
			SCREENED						NOT SCREENED		
	3	3									
	4	3					1				
	5	4								1	1
-1 S.D.											
	6	11						1		2	2
	7	9						1		1	
	8	5						1			
Mean	9	11				1					1
	10	8		1				2	1	1	2
	11	7									1
+1 S.D.											
	12	5		1			1				
	13	4		1		1			1		
	14	3					1	2			
	15	1									
	N =	74									

---

* T indicates teacher rating - 1 standard deviation above mean
P indicates peer rating - 1 standard deviation above mean
S indicates self rating - 1 standard deviation above mean

TABLE LVII

Comparison of Clinical Criterion With the Use of Various Patterns of Cut-Off Scores on Screening Materials - Second Grade Boys

Clinical Criterion Score	Distribution of Clinical Criterion in Project Sample	Frequency of Project Pupils With Combinations of Screening Patterns*								
		TPS	TP	PS	TS	1 qualified + 1 borderline rating	nominated + 1 or more qualified or borderline rating	T only	P only	S only
		SCREENED						NOT SCREENED		
3	1									
4	2									
5	5									
6	7						1		1	
-1 SD										
7	5						1			1
8	7							1		
Mean 9	9		1				1			3
10	11			1						1
11	8	1		1			1		1	1
+1 SD										
12	9					1	1			
13	3					1	1	1		
14	3									
15	2	1					1			
N =	72									

---

* T indicates teacher rating - 1 standard deviation above mean
P indicates peer rating - 1 standard deviation above mean
S indicates self rating - 1 standard deviation above mean

TABLE LVIII

Comparison of Clinical Criterion With the Use of Various Patterns of Cut-Off Scores on Screening Materials - Fifth Grade Girls

Clincial Criterion Score	Distribution of Clinical Criterion in Project Sample	Frequency of Project Pupils With Combinations of Screening Patterns*								
		TPS	TP	PS	TS	1 qualified + 1 borderline rating	nominated + 1 or more qualified or borderline rating	T only	P only	S only
		← SCREENED					→	← NOT SCREENED		→
3	2									
4	4									1
5	3									1
-1 SD										
6	3									
7	10						1		1	1
Mean 8	9			1					2	
9	9		1		1		1		2	2
10	7	1			1	2		1		1
+1 SD										
11	4		1		1					
12	3		1							1
13	0									
14	0									
15	1									
N =	55									

---

* T indicates teacher rating - 1 standard deviation above mean
P indicates peer rating - 1 standard deviation above mean
S indicates self rating - 1 standard deviation above mean

TABLE LVIX

Comparison of Clinical Criterion With the Use of Various Patterns of Cut-Off Scores on Screening Materials - Fifth Grade Boys

	Clinical Criterion Score	Distribution of Clinical Criterion in Project Sample	Frequency of Project Pupils With Combinations of Screening Patterns*								
			TPS	TP	PS	TS	1 qualified + 1 borderline rating	nominated +1 or more qualified or borderline rating	T only	P only	S only
			← SCREENED →						← NOT SCREENED →		
	3	2									
	4	2					1				
	5	3									
	6	5									
-1 SD											
	7	9								1	
	8	12					2	1			
Mean	9	15					2	1			
	10	10	1	1	1					1	
	11	12		1	1	1	2	1	1		
+1 SD											
	12	14			3	1		1			
	13	3	1	1			1				
	14	5	1	2							
	15	1						1			
	N =	93									

---

* T indicates teacher rating - 1 standard deviation above mean
P indicates peer rating - 1 standard deviation above mean
S indicates self rating - 1 standard deviation above mean

is screened. Eleven out of these sixty nine pupils or 16% of those screened would be false positive (having criterion scores below the mean criterion for the sample). One can see by reference to the tables that by using **only** one cut-off score without a nomination or another borderline score, the pupils who would be selected would tend toward mean scores with only a few in the range of high criterion scores. These pupils obviously need some further attention, but whether they would be included in the screening list would depend on other findings or they would be missed by the screening procedure.

Next the screening data were reviewed on pupils with criterion scores at least standard deviation above their means, but who were not screened using the two procedures described above. In each sample, the pupils who received criterion scores approximately one standard deviation above the mean (about the top twenty percent of the project group since the cut-off at one standard deviation above the mean often fell in the middle of a score) and who were not screened by the cut-off procedures were listed. All screening scores were divided into four groups: 1) Scores which one standard deviation above the norm group mean; 2) Scores which were from the mean to one standard deviation above the mean; 3) Below the mean to one standard deviation below the mean; 4) and those which were the most positive ratings at one standard deviation below the mean. Table LX presents the distributions of teachers ratings according to these four groups for each sample. Of thirty three pupils only eight (24%) had scores below the mean (misses) and four were more than one standard deviation above the mean. Table LXI lists similar results for the self ratings. In this table the scores on the Picture Game were reversed so that scores above the mean for both second and fifth grade can be considered negative. Here the results are not as promising. Two thirds of the group with high criterion scores had self ratings below the mean while approximately one fourth of them had scores which were more than one standard deviation below the mean. These are either very positive ratings of self or an inability to rate oneself realistically. Turning next to the peer ratings, the distributions of both the number of selections by peers and the number of negative selections are listed on Table LXII. In the distribution of the total number of selections by peers, one sees exactly the reverse of the distribution of teacher ratings. Of the pupils who were missed by the screening process, only four of the thirty three were selected by their peers an average or greater number of times. The second half of table LXII indicates that one half of this group had a peer rating with percent of negative selections above the mean.

These results suggest that pupils who are missed by the screening procedure are ones with teacher ratings above the mean and a low number of peer selections on the peer ratings. The Class Pictures and Class Play each contain twenty items. A typical class has about 32 to 35 pupils enrolled. Therefore, a pupil has one chance in 35 of being selected for any item, or 20 chances in 35 for being selected at least once. These probabilities are not exact since girls are picked more often for some items than boys so that the probability of selection varies from item to item and from test to test. Very low numbers of selections are hardly better than what could be expected by chance; therefore the percent of negative selections might vary greatly for any of these pupils. For example in the case of two girls who had high criterion scores one of whom was missed by the screening cut-off procedures, and the other selected, the one who was missed had only four selections by peers with one negative selection, and the one who was selected had nine selections with eight negative. The most significant finding in the case of both girls as far as the clinical criterion is concerned is evidently the fact that they were selected so few times. Additional light is shed on the sample of pupils with high criterion scores who did not

TABLE LX

Teacher Ratings of Project Pupils With Clinical Criterion Scores Approximately One Standard Deviation Above Mean Who Were Not Screened

Group	Total Teacher Rating			
	-1 S.D. below M	Mean to -1 S.D.	M to +1 S.D.	1 S.D. above M
Second Grade Girls			4	2
Second Grade Boys		5	4	2
Fifth Grade Girls			5	
Fifth Grade Boys		3	8	

TABLE LXI

Self Ratings (Picture Game - Second Grade and Number of Negative Self Choices, Class Play, Section II - Fifth Grade) of Project Pupils with Clinical Criterion Scores Approximately One Standard Deviation Above Mean Who Were Not Screened

Group	Self Rating *			
	-1 S.D. below M	Mean to -1 S.D.	Mean to +1 S.D.	1 S.D. above M
Second Grade Girls	2	4		
Second Grade Boys	1	6	4	
Fifth Grade Girls	2	1	1	1
Fifth Grade Boys	4	2	4	1

---

* For this table scores on Picture Game and Class Play were arranged so that scores above mean on both tests are considered negative.

TABLE LXII

Peer Ratings of Project Pupils With Clinical Criterion Scores Approximately One Standard Deviation Above Mean Who Were Not Screened

Group	Peer Rating - Total Number of Selections			
	-1 S.D. below M	M to -1S.D.	M to +1 S.D.	1 S.D. above M
Second Grade Girls	2	3	1	
Second Grade Boys	2	8	1	
Fifth Grade Girls	2	3		
Fifth Grade Boys	4	5	2	

Group	Peer Rating - % Negative Selections			
	-1 S.D. below M	M to -1 S.D.	M to +1 S.D.	1 S.D. above M
Second Grade Girls	2	2	2	
Second Grade Boys		2	9	
Fifth Grade Girls	3	0	2	
Fifth Grade Boys	1	6	4	

qualify on the cut-off procedures by recording their est. WISC IQ scores. Fifty six percent of those missed had above average or higher teacher ratings with total number of selections on the peer rating below the mean. Of these the average est. Verbal IQ on the WISC was 89.7; for the remaining pupils who had other patterns of screening scores, the average estimated Verbal IQ on the WISC was 102.7, close to the project sample average. Therefore the combination of low IQ (about 95 or below), above average teacher ratings and low number of selections by peers on the *Class Play* or *Class Pictures* selects about half of the project pupils with criterion scores one standard deviation above the mean who were missed in the multiple cut-off method. Four pupils or twenty two percent of this group were nominated by teacher or principal prior to the screening process -- two were nominated as having difficulty learning and two were nominated as often getting upset or sick in a stressful situation. Of the remaining pupils who were missed seven out of thirty three had screening and IQ scores in a variety of patterns, none of which lead to any meaningful generalizations. Only one of these pupils had a prior nomination, that of having difficulty learning even though his estimated WISC IQ was 131. Four had either a negative teacher or peer rating and a negative self rating indicating borderline scores on two instruments with no prior nomination. Four more of these pupils with high criterion scores who were missed by the screening process had either a teacher or peer rating which was negative and a self rating score which was more than one standard deviation below the mean indicating as mentioned above either a very positive self concept or an inability to rate oneself realistically. The remaining two of those who were missed had high negative scores on all three screening instruments, IQ scores of 85 and 96 and no nominations.

The multiple cut-off procedure described previously selects about 50 percent of the pupils with criterion scores one standard deviation above the mean for grade and sex. Half of those who were not selected by the cut-off procedure could have been picked up if a borderline negative teacher rating and a low total number of peer selections were combined with a low IQ score. About ten to fifteen percent with high criterion scores would have been completely missed by the cut-off procedure. The remaining misses might have been picked up if the teacher used the five highest scores on each rating in her class since two or more of their scores were borderline, or if the teacher combined very negative teacher or peer ratings with extremely high (more than one standard deviation below the mean) positive self perception (interpreted by the clinical teams as extreme defensiveness).

In summing up the cut-off procedures, the previous discussion has indicated that 84 percent of those screened would have achieved criterion scores at the mean or higher indicating either moderate or considerable emotional handicaps or school adjustment difficulties. Differences between the type of pupils selected as having most school adjustment problems who are not screened by the cut-off procedure appears to be accounted for in the most part by pupils with very low IQ scores who are not perceived to any great extent by classmates in peer ratings and evidently have a difficult time interacting either with peers or clinicians.

g. Recommended Screening Procedures

Two types of screening procedure have been presented. One uses a multiple regression procedure which weights each screening score so that the sum of the weighted scores provides a measure with the best prediction of the criterion. The second uses multiple cut-off procedures and the degree to which pupils with various patterns of multiple screening cut-off scores are selected by clinicians as ones with moderate or considerable school adjustment difficulties has been reviewed. Either procedure is considerably more effective in screening pupils with emotional handicaps manifest in school adjustment difficulties than school referral. A single rating by a previous teacher or a nomination by the present teacher have some merit as very rough screening devices and are best used in combination with a more comprehensive screening process.

1. Verification of Research Hypotheses by the Results of the Project

The research hypotheses and the findings which have been presented to accept or reject them are as follows:

1) Hypothesis 1

Children with mild or moderate emotional handicpas can be economically and effectively identified by use of a screening process. Two screening procedures have been described, a multiple regression procedure combining various patterns of scores on teacher, peer and self ratings, extimated WISC IQ's and an Index of Social Status Characteristics to predict an independent clinical criterion of emotional handicaps related to school adjustment status. Multiple R's varied from the lowest of .33 to the highest of .89 for the four samples. Considering the samples separately, a multiple R of .49 was the minimum which could be achieved in any of the samples by using the screening battery with the best selection power. A multiple cut-off procedure also yields significant results when the criterion scores of pupils who are in the cut-off range are studied. If the criterion score distribution can be accepted as covering a range of behavior from minimal to considerable emotional handicaps manifest in school adjustment difficulties, the data presented in the project substantially confirm research hypothesis 1.

2) Hypothesis 2

Such a screening process can be economically and effectively used by an entire school system. The fact that the screening process is effective has been justified in the discussion of hypothesis 1. Whether the process is economical can be determined on the basis of comparing the time taken to complete it with other available procedures for early identification of children vulnerable to school difficulties. At least two hours is required for the completion of the teacher rating, about four hours of classroom time spread over a two week period for administration of the peer and self ratings to the primary grades and two hours of class time for administration of the peer and self ratings to the elementary grades. Teachers vary in their rate of scoring the peer and self ratings, but the average time is about three hours. The clerical staff in the school can easily assist in scoring; therefore, for an investment of about five hours, on the average, of teacher time and about four hours of classroom time for the administration of the materials, it is possible to select a group of pupils who will be subsequently diagnosed by a clinical team as having moderate to considerable school adjustment difficulties. Without such a screening procedure, pupils are not identified until their problems reach a chronic stage and personnel available for testing and follow-up school conferences are available.

The screening process described here is economical as well as effective, since no other procedures for early identification are available and since it identifies pupils who are judged independently by clinicans to have emotional problems varying from moderate to extreme in the degree to which they are manifest in school adjustment.

3) Hypothesis 3

Screening instruments can be developed which individually and collectively meet the reliability and validity standards for such measurement. The validity of each of the screening scores has been studied by correlating the score with the criterion measure. The three ratings result in significant correlations with the criterion for the second and fifth grade samples of boys. The screening instruments fail to achieve consistent correlations with the criterion in all cases for second and fifth grade girls, but possible bias in the criterion score or differences in school and clinical perception of emotional and school problems in girls may account for the lack of significant correlation with the criterion. Several assumptions have been offered as to the source of the discrepancy, and some confirmation of the assumptions has been provided. Of importance is the fact that negative scores on both instruments have high criterion scores, but the distributions of the screening score and the criterion are not linear at the lower or positive end of the score range.

4) Hypothesis 4

The use of the "perceptual triad" (teacher, peer and self) in the screening process will identify children with similar degrees of emotional problems but with a wide variety of behavior manifestations. The nominations by teachers and principals prior to the administration of the screening materials provided the data to confirm or reject this hypothesis. In the case of all samples the multiple cut-off procedure was studied to determine the screening patterns of children with prior teacher or principal nominations. In every group of pupils who were in the multiple cut-off range, and who were screened by that procedure, there was at least one pupil with each of the different types of behavior manifestations which were defined in the nomination procedure. Therefore, the screening procedure selected children who had difficulty learning, problems in interpersonal relationships, inappropriate behavior, mood problems in being often unhappy or depressed or who were those who got sick or upset easily when faced with difficult school situations. The frequency of each nomination compared with criterion scores and the original teacher rating have been given for each of the groups which were nominated.

5) Hypothesis 5

The screening instruments can be combined into an Index of Alienation or Relatability which will be useful in measuring change in the mental health status of children. The results of this project suggest that the degree to which the multiple prediction batteries predict the clinical criterion is evidence for the possibility of combining the screening instruments alone or with other data into an Index of Alienation or Relatability. Further study of the sources of variation in the criterion should yield a method for improving the criterion score and subsequently a better prediction equation for each sample. Even though no discussion was provided of the characteristics of pupils with scores at the positive end of the distribution, the project staff reviewed these cases and found that low scores on the screening materials were just as predictive of low criterion measures as high scores were predictive of high criterion measures. While this fact could have been explored more in this report, the reader may be interested in further studying the possibility of using this procedure to select not only the children with the poorest school adjustment, but also the pupils with the best school adjustment or the fewest emotional handicaps as judged by the clinicians. Such a study should indicate that positive scores on the screening instruments select pupils with few school problems, with excellent coping powers, good personal resources, and the wherewithal to manage school with considerable success.

CHAPTER IX

CONCLUSION

Project 1186 was designed to validate a screening process using teacher, peer and self ratings which has been developed for early identification of pupils with emotional handicaps who are vulnerable to learning and behavior problems in school. In 1955 at the time the developmental work on the screening procedure was initiated, such children were being referred to as "emotionally disturbed." Later, realizing that this designation was confusing, at best, and not really descriptive of the learning and behavior problems of the pupils who were being identified by schools, the designation "emotionally handicapped" was selected. Even this term which implies a psychological rather than a social or physical handicap and which was defined operationally by describing the types of pupils to which it referred caused great confusion among educators and lay persons. The problem of designating the group of pupils who are vulnerable to school difficulty where the problem is not specifically one of a physical handicap or mental retardation remains. The pupils who are identified in the elementary school and in the secondary school as emotionally disturbed, emotionally handicapped or maladjusted are pupils who manifest a variety of learning and behavior problems and who have school adjustment difficulties. It is for this reason that the reader will find the terms "emotional handicaps" and "poor school adjustment" used interchangeably in the project. While the term "emotional handicap" was designed to focus on the fact that the pupils it labeled where ones with the basic prerequisites for school success, but ones who could not organize their resources to cope with the school and life situations, the term "poor school adjustment" focuses on the effects of the handicap. Follow-up studies of pupils who have been identified as ones with emotional handicaps or poor school adjustment indicate that these pupils are ones who later drop out of school, become delinquent, get poor grades, are regularly called up for disciplinary action, have more school absences, and ones who have little chance of succeeding in their educational program without assistance.

Regardless of the label attached to this group of vulnerable pupils, the fact remains that the most important step toward reducing the effects of the handicap or adjustment problem, is the earliest possible identification of an oncoming difficulty. Since behavior is a dynamic affair, teachers are reluctant to say that a child's behavior in a particular grade or at a particular age are the signs of a lasting school problem. Often this may be a correct interpretation. Any process of early identification is bound to turn up pupils who are struggling with a temporary difficulty and who, with some assistance, will manage to weather the storm. It is for this reason that no procedure for early identification should be abandoned because some of the pupils who are identified have problems of only a temporary nature. Even in such cases, increased help in the pupil's educational program is bound to assist him in managing his current difficulties.

Early identification procedures need to involve whole school populations so that every child with a potential school adjustment problem can be identified for help. This first phase in an early identification procedure is a screening process much like those procedures already used by schools in locating pupils with possible vision and hearing problems. A second diagnostic phase follows during which specialists determine the nature and degree of a child's difficulties and subsequently, in concert with school personnel, plan an appropriate educational program for him. Assignment of pupils with particular types of difficulties to the educational program which can best meet their needs is the topic for another study; nevertheless, the findings from the screening and diagnostic phase of the early identification program should be helpful in making an appropriate educational plan for a pupil in need of special assistance.

It is essential that the person in the school who has been designated responsible for the program of early identification of school adjustment problems be aware of the fact that approval from parents is necessary before any such program can succeed. The procedures used in Project 1186 are examples of ones which were followed which were quite successful in guaranteeing parent understanding of the purposes of the program as well as gaining their best cooperation. Until screening programs to locate pupils with adjustment difficulties are as commonly accepted as are programs for vision and hearing screening, no educator should take for granted the fact that he has parent's approval of the process regardless of his worthwhile and helpful intentions.

Early identification, then, requires two steps - a screening phase and a follow-up diagnostic phase. Project 1186 was designed to validate a screening procedure; some of the results include information which may be useful in assisting in the development of appropriate diagnostic methods. In order to validate the screening process it was necessary to obtain an appropriate sample of second and fifth graders. An initial rating of school adjustment which would not contaminate either the ratings of the clincians or the teachers who were to participate in the project was necessary. The teachers who had the pupils who were to be part of the study at the end of the school year prior to the start of the project rated every child on a scale of school adjustment. From these ratings a random sample of pupils from all of the classes was selected and parents were contacted in order to gain approval for their child to participate in the project.

Once the sample had been selected and parent approval obtained, five clinical teams, trained in advance by the project staff arranged for interviews with the family and child and collected factual data for their interview schedules. After completing their interviews, they rated each child on a number of behavior characteristics which had been selected as useful in predicting a child's school adjustment status. The clinicians made judgments of the child's health and physical status using any genetic or organic data which might play a role in a school problem, his social environment from an interview with the parent and a variety of psychological variables such as intelligence, perceptual difficulties, parent-child relationships, peer relationships, relation to reality, creative potential and so forth. These qualitative judgments of the project pupils which were made independently by each clinician without collaborating with other members of the clinical team or with school personnel resulted in a variety of ratings, each of which was selected to be predictive of some aspect of school adjustment. Finally all of the data were presented to each clinician along with criteria for school adjustment which were developed in the project and each clinician made a final, independent judgment of the child's school adjustment status. From a careful study of the relationships among the rating of the clinicians, the sum of the three final ratings of school adjustment was selected as the clinical criterion of school adjustment against which to validate the screening process. It is impossible to determine at this point whether the clinicians made perfect predictions of school adjustment simply because the group of pupils with moderate to extreme school difficulties with the exception of those with extremely severe adjustment problems, is not easily identified by the use of existing measurement procedures. However, this method did yield pupils on a continuum of good to poor school adjustment where each score on the continuum of good to poor school adjustment was determined independently of other data which were to be collected in the project.

When the criterion scores, the sum of the three final judgments of school adjustment status, had been determined for each project pupil, they were compared with the results of the administration of the screening process which had taken place in the Spring of the school year. Since the screening materials had been administered to all of the pupils who were in the classes with the project pupils, normative data on the teacher, peer and self ratings are available for second grade girls and boys and fifth grade girls and boys. Correlations of the scores on the screening materials for the project sample were then obtained and those correlations which were significantly different from chance at the 5% level were selected as evidence of the validity of the screening rating.

The scores on the screening process were then combined into a screening procedure. Multiple regression equations which combined the screening ratings with estimated WISC IQ scores and socio-economic status were found to have a significant relationship with the clinical criterion. The three screening ratings were also combined in a multiple regression equation and found to predict the criterion significantly though negative weights occurred in some samples. In addition a multiple cut-off procedure was studied and this was shown to yield useful results by comparing criterion scores of pupils with cut-off patterns. In both cases, either multiple prediction, or multiple cut-off, the screening materials were shown to provide an effective method of locating pupils who were judged independently by clinicians to have school adjustment difficulties. Improvement in the screening procedure can be obtained subsequently if some of the discrepancies between school observed problems and clinically observed problems are reconciled.

Some insight into the school characteristics of pupils with different criterion scores was provided by a survey of the data collected in the project which compared distributions for the well and poorly adjusted groups.

No research project is ever completed which does not suggest the way for further, possibly rewarding, research studies. Project 1186 is no different from the rest. The results of this project while substantially confirming the research hypotheses also suggest that contained within the data collected are possible solutions to the perplexing problems of using clinical data in a meaningful, predictive way rather than as data for descriptive summaries only. In addition the underlying sources of variation in developing the criterion groups should be evaluated to determine a method for more efficient use of clinical material. Factored clinical variables can then be compared with the typical case data collected in the process of clinical team investigation.

The results of Project 1186 indicate that the collection of data within the school setting which comprise ratings of behavior by teachers, peers and pupils as well as estimates of intelligence and socio-economic status can be meaningfully and usefully combined to screen a group of pupils who would later be diagnosed by clinicians as having from moderate to extreme degrees of emotional handicaps manifest in school adjustment difficulties.

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APPENDIX

Information Release

The purpose of this research project is to survey a random sample of second grade and fifth grade pupils in order to determine some of the non-intellectual factors which make children successful as well as unsuccessful in school.

The school and the State Department of Education are working on ways of helping children in school learn more effectively. Part of the study will focus on finding new ways of working with parents which can best help them help their child in school. It is hoped that as a result of the study, factors which are important in helping a child learn more effectively in school can be isolated, and a child who is beginning to have problems and needs special assistance can be identified and helped.

During the progress of the study, the information which the school has which is useful in planning more effective school programs for children, especially those who may have some difficulty learning, will be appraised.

Parents, teachers, businesses, labor unions, and universities are becoming increasingly alarmed by the fact that 30 percent of the children who start school do not finish, even though many of these children have the ability to succeed in school learning tasks. Without a high school education a person has a markedly reduced chance of succeeding as an adult. Many become dependent on society for help, either through unemployment insurance, public assistance, or institutionalization. A large segment of the welfare costs resulting from dependent individuals and families in our State can be reduced only by measures intended to prevent or reduce this problem. This study is based on the assumption that if schools can be helped to be more effective with a larger number of children, we can reduce the educational casualties and increase the number of adults in our population who can function as workers, parents, and citizens.

Nadine Lambert, Research Consultant
California State Department of Education

Sample Letter to Parents of All Second and Fifth Grade Pupils*

Our School District is cooperating with the State Department of Education on a research project which will involve second and fifth grade pupils in our school. The purpose of this project is to survey a sample group of children to find out what characteristics might differentiate between a child who will have problems in learning and social adjustment and one who will not have these problems. Children in the sample group will be picked at random so that an average group of children will be studied. Most of them will have few - if any - learning or social adjustment problems.

If your child's name has been drawn, he will be a member of the sample group. You can, then, expect the school to notify you that a social worker will interview you in your home. Although the questions she might ask you will not be of a highly personal nature, anything said during the interview will be completely confidential. The social worker will be getting information for the research project - not for the school. In addition to asking you questions, she will explain to you the next step of the study.

You may, for personal reasons, prefer not to participate in this project. However, we believe that you share our concern for the many children in our public schools who have special learning problems requiring special attention. It is only through a careful study of an average group of pupils that we can learn to recognize early the child who, in spite of average or good ability, will eventually become a school failure. And it is only through early recognition that we will be able to make plans for preventing eventual failures.

The fact that a child has been selected to participate in this project does not mean that he has any special problem nor that he has no special problems. If your child has been chosen as a member of the sample group, you will know that his name was selected on the basis of chance. Conversely, if your child has not been chosen as a member of the group, you will know that his name was eliminated on the basis of chance.

If you would like further information, you may call your Principal or the District Psychologist.

Thank you for your assistance in this project.

Sincerely,

School Principal

School Psychologist

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* Mailed to parents of all second and fifth grade pupils prior to phone call by the school secretary to make appointment for home call by social worker. This procedure for gaining parent cooperation for the project was used by two of the eleven schools.

Sample Letter to Parents*
of Project Sample Pupils in Second and Fifth Grade

The schools and the State Department of Education are cooperating in a research study to determine factors which affect school learning. A small number of children in the second and fifth grades have been selected at random to represent typical youngsters of that age and grade. Your child's name was selected, and we would like very much for you to assist us in this project. If you are interested, will you please return the tear-off sheet at the bottom of this letter? A research worker will make an appointment to discuss the project further with you.

It is hoped that the results of this study will enable us to discover ways in which home and school can work better together and educational methods which might be of help in assisting each child's learning progress. We would appreciate your cooperation and participation.

. . . .

I am interested in having my child participate in the research project of the California State Department of Education.

Name ______________________ Address ______________________

Child's Name ________________ Birthdate ____________________

Phone ______________________

This procedure for gaining parent cooperation for the project was used by nine of the eleven schools.

* Mailed to parents of pupils on project list in Fall, 1961, prior to home call by social worker

Sample Notice to be Sent Home Prior to Screening

School ____________

Date

Dear Parent:

The school and the State Department of Education are cooperating in a research study to determine factors which affect school learning. During the next few weeks your child will be involved in some additional testing. This program will take a minimum of class time. The results of this study should enable us to better assist pupils in their school learning by identifying early those pupils who need additional help.

We appreciate your cooperation.

Permission Slip for Individual Evaluation

___________ School

The school has my permission to arrange for ____________________________ (child's name) to be given tests of ability by a child psychologist and to be interviewed by a child psychiatrist at school during the 1961-1962 school year

____
Parent's signature

____
Date

PRINCIPAL AND TEACHER RATINGS FOR PROJECT 1186

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2. Principal, Teacher and Nurse Nominations (1961 and 1962) ... 11

How to Complete the Teacher's Rating of School Adjustment

Introduction

Most children who go to school are able to get along fairly well in learning tasks and are able to have rewarding experiences with peers and adults. The child who adjusts well to school is one who learns from his experiences; one who is able to spend his time on a variety of activities; one who has the ability to undergo stressful experiences without collapsing emotionally; one who is physically healthy; and one who is enthusiastic about life in general. The child who adjusts well is one of the majority of children in school and while he may or may not be the best student in class, he can be described as one who can exercise a variety of choices in his behavior and is comfortable with such freedom.

One can judge the degree to which a child can adjust to life and school from the degrees of freedom he has in choosing from among alternative kinds of behavior. Often one can infer a rigidity in a child's personality which causes him to have learning or behavior problems not amenable to ordinary corrective measures. Such limitations also serve to reduce the child's relative freedom of choice in other social and educational endeavors. The reduction of personal maneuverability and flexibility increases the child's difficulties in adapting to the pressures and changes in life. As a result, the child with emotional handicaps shows increasing susceptibility to behavioral difficulties and interpersonal friction.

Specifically, the child with poor school adjustment is defined as having moderate to marked reduction in behavioral freedom, which in turn reduces his ability to function effectively in learning or working with others. In the classroom, this loss of freedom affects the child's educative and social experiences and results in a noticeable susceptibility to one or more of the following five patterns of behavior:

1. An inability to learn which cannot be adequately explained by intellectual, sensory, neurophysiological or general health factors.
2. An inability to build or maintain satisfactory interpersonal relationships with peers and teachers.
3. Inappropriate or immature types of behavior or feelings under normal circumstances.
4. A general pervasive mood of unhappiness or depression.
5. A tendency to develop physical symptoms, such as speech problems, pains or fears associated with personal or school problems.

To sum up, the significant patterns of behavior in children indicative of poor school adjustment are: Inability to learn, unsatisfactory interpersonal relationships, inappropriate behavior, unhappiness, repetitive symptoms of illness after stress.

Part I - Completing the Rating Grid

Obtain a roster of the class which you are rating. Next, with the roster of names and the form "Teacher's Rating of School Adjustment", follow the instructions below and complete the rating grid:

Your rating job is to locate every pupil in the class on a scale that runs from "best adjusted" to "poorest adjusted" and place the names on the pyramid.

1. Look at your list of pupils and identify those who you think are most typical of a well-adjusted student. You will note that there are only two boxes at the extreme left of the pyramid (column 1). Choose the pupils who were the best adjusted in your class last year and write their names in the boxes in column 1 of the pyramid, one name to a box.

2. Next look at your list of students and identify those who were the poorest adjusted in your class and write their names in the boxes in column 7 of the pyramid, one name to a box.

3. Now return to your list and again identify from the remaining students those who were well adjusted, but not as well adjusted as the two in column 1. Write their names in column 2.

4. Again, return to your list of pupils and identify other students in the class who were poorly adjusted, but with less handicaps than those in column 7. Write their names in column 6. Continue in this way until all names have been used.

5. When you have completed the ratings, you should have on the right, pupils who were most poorly adjusted, and on the left, those who were the best adjusted in your class.

6. Use the boxes shown with dotted lines only if you have a large class and find you do not have enough spaces for all your students. Be sure that each pupil's name is placed in only one box. Some teachers check off names on the class list with light pencil marks to keep track of names used.

7. Try your best to complete the boxes in columns 1 and 7 first, columns 2 and 6 second, and in columns 3 and 5 last. If you cannot completely fill these columns, use dashes to indicate that the boxes have not been overlooked or omitted. Some teachers who have small classes or insufficient contact with some children may find it necessary to omit names in several of the boxes. If you feel uncertain about placing a child near either extreme of the rating scale, place his name in the middle column, column 4. When you have completed the ratings, the name of every child in your class should be found in one of the seven columns of the pyramid. Unused boxes should have dashes in them.

Part II - Nominations of Children with Learning and Behavior Problems

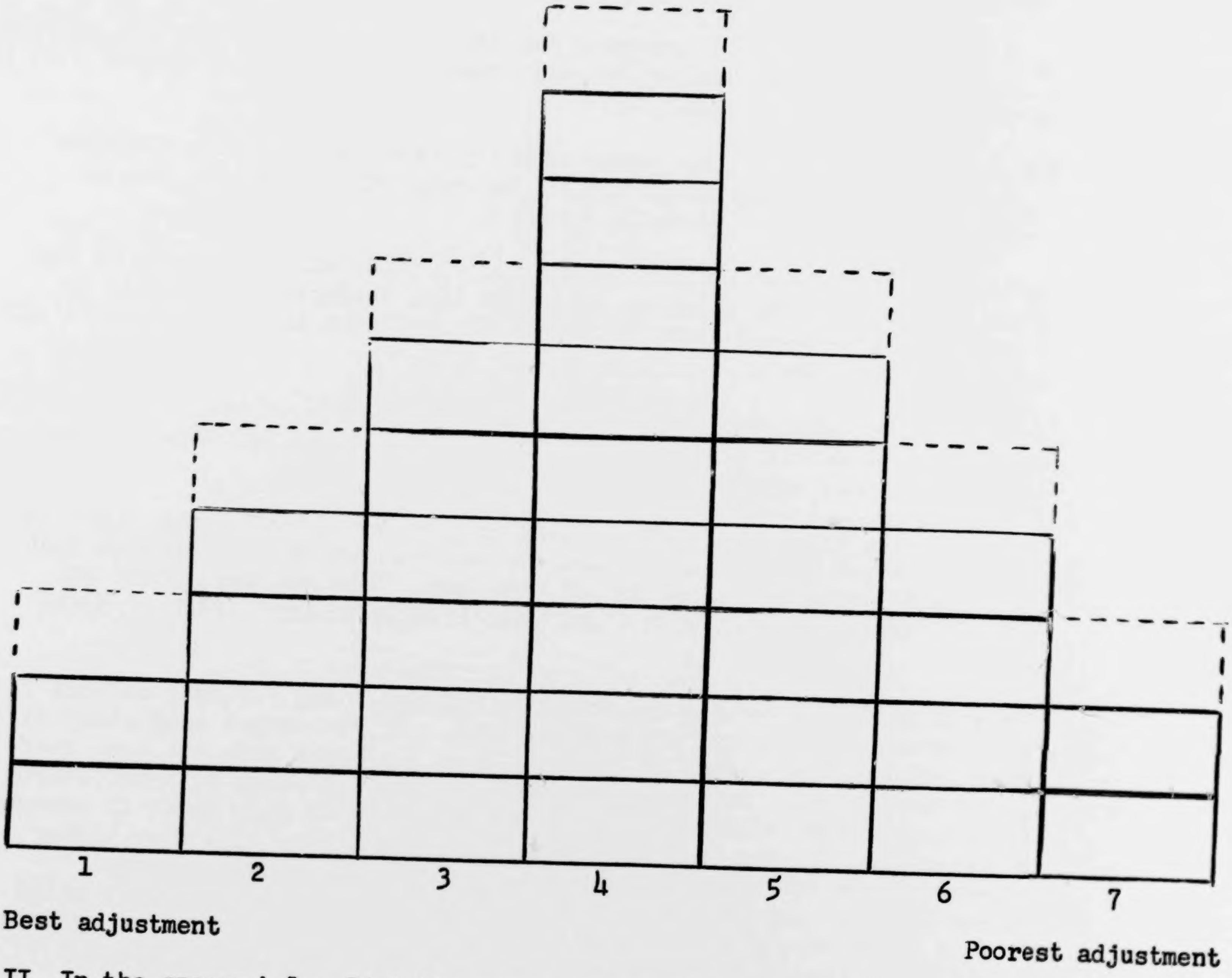
At the bottom of the sheet with the pyramid are places for you to list the names of pupils in your class last year who were best described as having one of the difficulties listed to a marked extent over a period of time. The behavior you note should have been typical of the child through last school year and not a problem which was transitory. Some children can be typified by more than one of the statements; in that case write their names opposite the problem which was the most serious one for them. Try to think of children in each of the categories, but do not worry about where they are placed on the pyramid above. Part II of your rating is for comparison with other information about the children in the class.

Teacher's Rating of School Adjustment

Name of Teacher ____________________

Part I

Grade of Pupils during 1961-1962 ________


1
2
3
4
5
6
7
Best adjustment
Poorest adjustment

Part II In the spaces below list the names of any children in this class who had any of the following problems to a marked extent over a period of time:

1. Inability to learn ____________________
2. Unsatisfactory interpersonal adjustments ____________________
3. Unhappiness ____________________
4. Inappropriate behavior ____________________
5. Repetitive symptoms of illness after stress ____________________

Nominations of Children with Learning and Behavior Problems

Name of Teacher, Principal or Nurse ____________________ Grade ____ School ____________

Introduction

One can judge the degree to which a child can adjust to life and school from the degrees of freedom he has in choosing from among alternative kinds of behavior. Often one can infer a rigidity in a child's personality which causes him to have learning or behavior problems not amenable to ordinary corrective measures. Such limitations also serve to reduce the child's relative freedom of choice in other social and educational endeavors. The reduction of personal maneuverability and flexibility increases the child's difficulties in adapting to the pressures and changes in life. As a result, the child with emotional handicaps shows increasing susceptibility to behavioral difficulties and interpersonal friction.

Specifically, the child with poor school adjustment is defined as having moderate to marked reduction in behavioral freedom, which in turn reduces his ability to function effectively in learning or working with others. In the classroom, this loss of freedom affects the child's educative and social experiences and results in a noticeable susceptibility to one or more of the following five patterns of behavior:

1. An inability to learn which cannot be adequately explained by intellectual, sensory, neurophysiological or general health factors.
2. An inability to build or maintain satisfactory interpersonal relationships with peers and teachers.
3. Inappropriate or immature types of behavior or feelings under normal circumstances.
4. A general pervasive mood of unhappiness or depression.
5. A tendency to develop physical symptoms, such as speech problems, pains or fears associated with personal or school problems.

To sum up, the significant patterns of behavior in children indicative of poor school adjustment are: inability to learn, unsatisfactory interpersonal relationships, inappropriate behavior, unhappiness, repetitive symptoms of illness after stress.

Nominations of children with learning and behavior problems

In the spaces below after each statement, list the names of children who are best described as having one of the difficulties listed to a marked extent over a period of time. The behavior you note should have been typical of the child through the school year and not a problem which has been transitory. Some children can be typified by more than one of the statements; in that case write their names opposite the problem which was the most serious one for them, list as many children as you can think of for each category.

1. Inability to learn ______________________________
2. Unsatisfactory interpersonal adjustments ______________________________
3. Unhappiness ______________________________
4. Inappropriate behavior ______________________________
5. Repetitive symptoms of illness after stress ______________________________

Pupil Data Sheet - Ability and Achievement

Card 1

Name ____________
Address ____________
School ____________
Birthdate ____________
____

Column

1 - 3 ________ Pupil Code Number
4 ________ Grade (code)
5 - 6 ________ School (code)
7 ________ Sex (0 = boys, 1 = girls)
8 - 9 __01__ Card Number

10 ________ Project Pupil (0 = not in project, 1 = 30%, 2 = 70%)
11 ________ 1961 Rating Code
12 ________ 1962 Principal Nomination
13 ________ 1962 Nurse Nomination

14-16 ________ Average C.A. in months of children in this grade in May 1962

B2 = 88 B3 = 100 B4 = 112 B5 = 125 B6 = 136
A2 = 94 A3 = 106 A4 = 118 A5 = 131 A6 = 142
Second grade = 98 Fifth grade = 134

17-19 ________ Age in May 1962
Months
20-22 ________ Difference between grade age and chronological age

23-25 ________ Most recent Ability Test Score
26 ________ Name of Test (code) ____________
27-29 ________ Age at time of Test - Date Given: Month ______ Year ______
Months
30 ________ Name of Most Recent Reading Test ____________ Name of Test
Code
31-33 ____ ____ Reading Test Grade Placement
yr. mo.
34-36 ____ ____ Actual Grade Placement at time of test ________ Date of Test
yr. mo.
37-39 ____ ____ Difference between test grade and actual grade placement
yr. mo.

40 ________ Name of Most Recent Arithmetic Test ____________ Name of Test
Code
41-43 ____ ____ Arithmetic Test Grade Placement
yr. mo.
44-46 ____ ____ Actual grade Placement at time of test ________ Date of Test
yr. mo.
47-49 ____ ____ Difference between Test Grade and Actual Grade Placement
yr. mo.

First semester grades - January 1962

50 ________ Grade in Reading
51 ________ Grade in Arithmetic
52 ________ Grade in Language
53 ________ Grade in Social Studies

Code

0 = F
1 = D
2 = C
3 = B
4 = A

Pupil Data Sheet - 1 continued

Citizenship Grades - January 1962

54 ________ Number of Outstanding Marks
55 ________ Number of Satisfactory Marks
56 ________ Number of Unsatisfactory Marks

0 = None
1-9 = Number of Each

Attendance at end of fall semester - January 1962

57-58 ________ Number of days absent (round off to nearest whole day)
59-60 ________ Number of days tardy

61 ________ Referrals

1 = Guidance office
2 = Child Welfare and Attendance
3 = Health
4 = Other, List ________________

62-63 ________ Occupation of father, List ________________________
64-65 ________ Occupation of mother, List ________________________
66-67 ________ Code for residential area
68 ________ Foreign language spoken in home

0 = No
1 = Yes
2 = Other - list ________________

69-76 ________ First 8 letters of last name

77-80 ________ First 4 letters of student's first name

Pupil Data Sheet - Health and Referrals

Card 2

Name ____________
Address ____________
School ____________
Birthdate ____________

Column

1 - 3 ________ Pupil Code
4 ________ Grade
5 - 6 ________ School
7 ________ Sex
8 - 9 ___02___ Card Number
10 ________ Project Pupil (0 = not in project, 1 = 30%, 2 = 70%)
11 ________ 1961 Rating Code
12 ________ 1962 Principal Nomination
13 ________ 1962 Nurse Nomination
________ Birthdate (month, day, year)

14-15 ________ Marital status of parents (list 2 if necessary)

1 = married
2 = divorced
3 = separated
4 = step mother
5 = step father
6 = mother deceased
7 = other

16 ________ Birth order of pupil
17 ________ Number of sibs
18-21 ________ Date entered this school
mo. yr.
22-24 ________ Most recent height
inches
25-27 ________ Age at date taken - Date taken: ________ month ________ year
months
28-30 ________ Most recent weight
pounds
31-33 ________ Age at date taken - Date taken: ________ month ________ year
months
34 ________ Vision defect (0 = none, 1 = yes)
35 ________ Hearing defect (0 = none, 1 = yes)
36 ________ Other handicaps - list: ________ ________ ________

Comments - if necessary

____

____

____

____

SOCIAL WORKER'S INTERVIEW PROCEDURES

Page

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2. Explanation of Physical Environment and Socio-Economic Categories 27
3. Revised Scale for Rating Occupation 30

Social Worker's Interview Schedule

Name of Child ____________________ Date ________ Social Worker ____________
Address ____________________
Age of Child ____________________
School ____________________ Grade ________

_____ Persons Present During Interview

0 = mother	5 = other adult
1 = father	6 = mother and children
2 = mother and father	7 = father and children
3 = mother and other adult	8 = mother, father and children
4 = father and other adult	9 = other adults and children

_____ Person Reporting

1 = mother	4 = other adult, related ________
2 = father	5 = other adult, not related _____
3 = mother and father	

_____ Length of Interview

1 = less than an hour	3 = more than an hour
2 = one hour	4 = two hours or more

_____ Noticeable Racial or National Factors

0 = none	3 = non-white foreign born
1 = white, foreign born	4 = accent
2 = non-white native	5 = other

_____ Reception

1 = very positive	3 = negative
2 = positive	4 = very negative

_____ Reaction to Consent Request

1 = no resistance	3 = resistance
2 = troubled, but consent	4 = refused

Special Comment:

____

____

____

____

School Adjustment

_____ What more can school do to help the child?

1 = satisfied
2 = more academic
3 = more attention to special needs
4 = change in homework
5 = more chance to be creative
6 = more opportunity to perform in class
additional attention, generally satisfied
7 = no idea
8 = no inquiry
9 = insufficient information

_____ Achievement

1 = above grade
2 = below grade
3 = at grade level
4 = average to below grade level
5 = average to above
6 = don't know
9 = insufficient information

_____ Can the child do better?

1 = yes
2 = yes, but no motivation
3 = perhaps
4 = no
5 = doing fine
6 = divided parents
7 = recognized emotional strain
9 = insufficient information

_____ Reading Materials

0 = ample, lots of things, much reading
1 = not much, very little reading
2 = Bible stories
3 = Golden books
4 = children's literature
5 = comics
6 = picture books
7 = classical literature
8 = adult literature - encyclopedia
and reference books
9 = insufficient information

_____ *Family Educational Goals*

1 = indifferent
2 = complete high school or trade
3 = college
4 = children not good in school
5 = wants them to participate within
ability level
8 = none expressed
9 = insufficient information

_____ Use of Library

1 = regularly
2 = irregularly
3 = rarely
4 = never
5 = likes to read
6 = school library only
9 = insufficient information

_____ School Contacts, PTA

1 = regular attendance
2 = periodically, or not much
3 = rarely attends
4 = never attends, no satisfaction
5 = father attends
9 = insufficient information

_____ School Contacts, School Conferences

1 = yes
2 = no
3 = occasionally
4 = no satisfaction
5 = father attends
9 = insufficient information

_____ School Contacts, Open House

1 = yes, 2 = no, 3 = other, 9 = insufficient information

Developmental History

_____ Pregnancy

1 = planned
2 = unplanned
3 = adopted and foster
8 = no inquiry
9 = insufficient information and other unknown factors

_____ Pre-natal Medical Care

1 = from very start
2 = yes
3 = not until last month
4 = none
8 = no inquiry
9 = insufficient information

_____ Mother's Health During Pregnancy

1 = poor
2 = good
3 = problems noted
9 = insufficient information

_____ Birth

1 = premature - 8 months or earlier
2 = term, 8 - 10 months
3 = at 10 months
8 = no inquiry
9 = insufficient information

_____ Labor

1 = normal
2 = prolonged - over 12 hours
3 = very short
4 = difficulties
8 = no inquiry
9 = insufficient information

_____ Delivery

1 = normal
2 = breach
3 = Caesarean
4 = forceps
5 = induced labor
8 = no inquiry
9 = insufficient information

_____ Birth Weight in Pounds

_____ Health

1 = good
2 = poor
3 = special problems noted
8 = no inquiry
9 = insufficient information

_____ Feeding

1 = breast-fed only
2 = breast-fed and bottle
3 = bottle only
8 = no inquiry
9 = insufficient information

_____ Type of Feeding

1 = schedule
2 = demand
3 = varied
8 = no inquiry
9 = insufficient information

_____ Feeding Problems

1 = none
2 = problem with formula
3 = food allergies
4 = weak nurser
5 = some problems noted
8 = no inquiry
9 = insufficient information

_____ Weaned at Age (age in months)

_____ Age at Which Bowel Trained

1 = before 1 year
2 = from 1 year to 18 months
3 = from 18 months to 2 years
4 = from 2 years to 2½ years
5 = from 2½ years to 3 years
6 = no problems
7 = at later time, example: 5 years
8 = no inquiry
9 = insufficient information

_____ Age at Which Bladder Trained

(use above code but substitute 7 = accidents in school, etc.)

_____ Age at Which Dry at Night

0 = does not remember
1 = 2 years
2 = 3 years
3 = 4 years
4 = 5 years
5 = 6 years
6 = 7 years
7 = older than seven
8 = enuretic
9 = insufficient information

Health Factors

_____ Eating Habits

1 = fussy
2 = no problem
3 = food allergy
4 = compulsive eater
5 = light eater
6 = overweight
7 = diabetic
8 = no inquiry
9 = insufficient information

_____ Sleeping Pattern

1 = regular
2 = irregular
3 = regular but light or very little
4 = regular but sleeps great deal
5 = past problems
8 = no inquiry
9 = insufficient information

Sleeping Difficulties

_____ Nightmares

0 = never
1 = at some time
2 = throughout life
3 = at present time
8 = no inquiry
9 = insufficient information

_____ Insomnia

0 = never
1 = at some time
2 = at present time
3 = throughout life
4 = some peculiarity; bouncing, bumping head, etc.
8 = no inquiry
9 = insufficient information

_____ Sleepwalks (use same code as for insomnia)

Childhood Illnesses

______ Chronic

0 = none
1 = severe respiratory infections, colds, bronchitis, pneumonia, whooping cough, tonsilitis, otitis
2 = acute infectious fevers
3 = rheumatic fever
4 = severe allergies & asthma
5 = orthopedic
6 = convulsions
7 = skin diseases
8 = other, not classified
9 = insufficient information

______ Duration of Chronic Illness

1 = less than 6 months
2 = 6 months to 1 year
3 = 1 to 2 years
4 = 2 to 3 years
5 = 3 to 4 years
6 = over 4 years
8 = no inquiry
9 = insufficient information

______ Acute Illnesses

0 = none noted
1 = mumps
2 = chicken pox
3 = measles
4 = scarlet fever
5 = pneumonia
6 = childhood diseases
7 = now under medical care
8 = no inquiry
9 = insufficient information

______ Accidents

0 = none
1 = broken bones
2 = severe lacerations
3 = head injury
4 = severe bruises
5 = stomach pumped
6 = eye
7 = teeth
8 = no inquiry
9 = insufficient information

______ Surgery

0 = none
1 = yes
2 = type ______
3 = minor amputation (finger)
4 = multiple
8 = no inquiry
9 = insufficient information

______ Duration of Hospitalization

0 = none
1 = 1 to 3 days
2 = 3 days to 1 week
3 = 1 week to 2 weeks
4 = 3 weeks to 1 month
5 = over 1 month
8 = no inquiry
9 = insufficient information

______ Number of Hospitalizations

_____ Types of Discipline Involved

1 = withholding privileges
2 = corporal punishment
3 = appropriate for offense
4 = flexible
5 = punitive
6 = raising voice, scolding
7 = isolation
8 = no inquiry
8 = insufficient information

_____ Sibling and Child Relationship

0 = no sibs
1 = never any problems
2 = some problems
3 = quite a few problems
4 = indifferent
5 = problem with older sib
6 = problem with younger sib
8 = no inquiry
9 = insufficient information

_____ Child's Relationship in Household

1 = frequently included in parent activity
2 = housekeeper (good), grandmother or adult
3 = limited amount of responsibilities
4 = seems to be very little
5 = no interest
6 = mother +, father -
7 = conflict
8 = no inquiry
9 = insufficient information

Socio-Economic Factors

_____ Description of House

1 = excellent
2 = very good
3 = good
4 = average
5 = fair
6 = poor
7 = very poor
8 = other

_____ Neighborhood - Dwelling Area

1 = very high
2 = high
3 = above average
4 = average
5 = below average
6 = low
7 = very low
8 = other

_____ Source of Income

1 = inherited wealth
2 = earned wealth
3 = profits & fees
4 = salary
5 = wages
6 = private relief
7 = public relief
8 = other

_____ Occupation of Father or Principal Wage Earner

1 = professional - level (check one) 1. ___ 2. ___ 3. ___

2 = proprietors and managers
level (check one) 1. ___ 2. ___ 3. ___ 4. ___ 5. ___ 6. ___

3 = business men - level 1. ___ 2. ___ 3. ___

4 = clerks and kindred workers, etc.
level 1. ___ 2. ___ 3. ___ 4. ___ 5. ___

5 = manual workers - level 3. ___ 4. ___ 5. ___ 6. ___ 7. ___

6 = protective and service workers
level 4. ___ 5. ___ 6. ___ 7. ___

7 = farmers - level 1. ___ 2. ___ 5. ___ 6. ___ 7. ___

Peer Relationships

______ Amount of Participation with Peers

1 = makes friends easily
2 = makes few friends
3 = plays alone most of the time
4 = limited opportunity for play with others
5 = constantly active with others
6 = average - some friends
8 = no inquiry
9 = insufficient information

______ Types of Activities

1 = active games
2 = doll play
3 = inactive games
7 = demands adult entertainment
8 = no inquiry
9 = insufficient information

______ Number of Younger Friends (1 = 1 or few friends, 4 = many friends)

______ Number of older friends " " " " "

______ Number of Friends Same Age " " " "

______ Total Number of Friends " " " " "

______ Sex of Friends

1 = same sex only, 2 = opposite sex only, 3 = mixed

______ Type of Relationship with Friends

1 = leader
2 = follower
3 = submissive
4 = aggressive
5 = leader and aggressive
6 = follower and submissive
7 = follower and aggressive
8 = difference between home and school relationships
9 = insufficient information

Family Relationships

______ Mother and Child Discipline

1 = easy to discipline
2 = has to discipline frequently
3 = difficult to discipline
4 = some problems noted
5 = no problems noted
6 = father takes charge
8 = no inquiry
9 = insufficient information

______ Father and Child Discipline

1 = more strict than mother, or takes responsibility when home
2 = less strict than mother
3 = in charge of all discipline
4 = would guess inconsistent
5 = same discipline by father
6 = no father in home
7 = no mother in home
8 = no inquiry
9 = insufficient information

______ Consistency

1 = mentioned by parents
2 = not mentioned by parents
3 = would guess consistent
4 = would guess inconsistent
8 = no inquiry
9 = insufficient information

Marital Status

_____ Years married, present marriage
_____ Number of divorces
_____ Number of separations
_____ Number of deaths

Religion

_____ Attendance at church

1 = no
2 = Protestant
3 = Catholic
4 = Jewish
5 = yes
6 = Budhist, Greek Orthodox
9 = insufficient information

_____ How often attend

1 = never
2 = weekly
3 = monthly
4 = irregular
5 = excessive, 5 times a week
6 = divided
8 = no inquiry
9 = insufficient information

_____ Relation of Family with Neighborhood

1 = isolated
2 = isolated, but changing
3 = average
4 = average, but changing
5 = excessive
6 = excessive, but changing
9 = insufficient information

_____ Composition of Household

0 = mother, father & only child
1 = mother, father & children
2 = mother and only child
3 = father and only child
4 = mother and children
5 = father and children
6 = mother, other adult and child
7 = father, other adult and child
8 = mother, father, other adult and only child
9 = mother, father, other adult and children

_____ Number of Sibs

_____ Birth Order of Child

Leisure Time Activities - Child

______ Clubs
______ Individual sports
______ Group games
______ Group game spectator
______ Play with other children
______ Hobbies
______ Reading
______ Special lessons
______ Television
______ Special solitary activities - not hobbies (chemistry set)
______ Chess

Leisure Time Activities - Parents

______ Club work and group activities
______ Fishing, hunting, camping
______ Sports participation
______ Sports spectator
______ Reading
______ Hobbies
______ Television
______ Theater, music, art
______ Visiting, entertaining
______ Civic responsibilities
______ Second job
______ Other ____________

Qualitative Judgments

______ Does this child have serious physical problems?

______ Has this child's development shown deviant psychological patterns?

______ Has the social environment in which the child lives been conducive to poor development?

______ Is this a family which would produce a child with serious learning and behavior problems?

______ Does this child have serious personality problems?

______ Does this child have school adjustment problems?

______ Does this child have school learning problems?

Specific Items to Elicit Affective Response from Parent

A. Specific Questions Regarding Affect

______ 1. Does the mother have a baby book with the child's history?

0 = none, 1 - 8 = number of years kept, 9 = insufficient information

______ 2. Did the mother purchase Spock or other books on child care? ______________

______ 3. Are there photographs of the child? ______ Formal ______ Candid __________

______ 4. What is the routine at bedtime?

1 = child goes to bed alone
2 = mother puts child to bed
3 = father puts child to bed
4 = mother or father puts child to bed
5 = problems
6 = child cries himself to sleep
8 = no inquiry
9 = insufficient information

______ 5. Does the mother read to the child? ______ How often? ______

______ 6. What did mother do when the child cried?

1 = ignored the child
2 = found out what might be wrong
3 = held baby and comforted
4 = had problem knowing what to do
5 = does not remember
8 = no inquiry
9 = insufficient information

______ 7. How many children come into the home to play? ______

B. Attitudes about Education

______ 1. How do parents feel about sex education in the school?

______ 2. Do parents think the schools should teach about religion?

______ 3. Do parents think schools should teach about communism?

C. Parental Views

______ 1. Do you think that all children shoul go to school, including retarded, physically handicapped, and trouble makers?

______ 2. What should the school do about trouble makers?

1 = discipline them
2 = special schools, separate classes
3 = expel them
4 = get help for them
5 = have to tolerate
6 = have parents discipline them, refer to parents
7 = find out the cause

______ 3. Do you feel you have any direct or indirect control over what the school does?

______ 4. What sort of programs do you think the school should have that it does not have now?

______ 5. Do you think physical education should be included in school programs?

______ 6. What do you think are the characteristics of a good teacher?

Summary of Social Worker's Interview

Factor Noted	Was anything learned, positive or negative, which might have affected wholesome development?				Criteria If answer is yes, what was it?
Physical Factors	yes (+)	No (-)	Maybe(+)	No Inquiry	
A. Genetic: congenital defects and heredity factors such as mental retardation, epilepsy, diabetes					
B. Defects: child's health history, including pregnancy, illnesses, sensory organ defects, accidents or nutrition					
Psychological Factors A. Parent-child relationships: past or present					
B. Other Adult-child Relationships: including relative, professional person such as doctor, teacher, minister, or boarder, etc.					
C. Sibling Relationships: child's relationship with brothers and sisters					
D. Peer Relationships: child's relationship with peers					
Social Factors					
A. Economic Deprivation: family's past or present economic situation (including relief status, inadequate housing, food or clothing)					
B. Norm Conflict: presence of cultural conflict (including possible racial, national, religious, class or urban-rural factors between child's parents or between family and neighborhood					
C. Social Disorganization: community characterized by social disorganization (anomie) or anti-social patterns (including presence of delinquent sub-cultures)					
D. Social Mobility: family's geographic mobility (including the frequent moving locally or city to city					

Global Judgment: If you marked "yes" or "maybe" to any factor or factors, do you see this as being related to child's school performance?

_____ yes _____ maybe no _____ other _____

How do you see this expressing themselves in school performance? ______________________

Explanation of Physical Environment and Socio-Economic Categories for Section III(1)

Description of house

Rating 1. Excellent houses

This includes only houses which are very large single-family dwellings in good repair and surrounded by large lawns and yards which are landscaped and well cared for. These houses have an element of ostentation with respect to size, architectural style, and general condition of yards and lawns.

2. Very good houses

Roughly, this includes all houses which do not quite measure up to the first category. The primary difference is one of size. They are slightly smaller, but still larger than utility demands for the average family.

3. Good houses

In many cases they are only slightly larger than utility demands. They are more conventional and less ostentatious than the two higher categories.

4. Average houses

One-and-a-half to two-story wood-frame and brick single-family dwellings, conventional style, with lawns well cared for but not landscaped.

5. Fair houses

In general, this includes houses whose condition is not quite as good as those houses given a 4 rating. It also includes smaller houses in excellent condition.

6. Poor houses

In this, and the category below, size is less important than condition in determining evaluation. Houses in this category are badly run-down but have not deteriorated sufficiently that they cannot be repaired. They suffer from lack of care but do not have the profusion of debris which surrounds houses in the lowest category.

7. Very poor houses

All houses which have deteriorated so far that they cannot be repaired. They are considered unhealthy and unsafe to live in. All buildings not originally intended for dwellings, shack, and over-crowded buildings. The halls and yards are littered with junk, and many have an extremely bad odor.

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(1) Warner, W. L., *Social Class in America*. New York: Harper & Brothers, 1960.p149-150

Description of Neighborhood - dwelling area (2)

Rating 1. Very high - In most towns this includes but one area. Residents, aware that this area has a high status reputation, remark that "no one can live here unless his family has lived in the community for at least three generations." The best houses in town are located in such an area. The streets are wide and clean and have many trees.

2. High - Dwelling areas felt to be superior and well above average but a little below the top. There are fewer mansions and pretentious houses in such a district than in the first. However, the chief difference is one of reputation.

3. Above average - A little above average in social reputation and to the eye of the scientific observer. This is an area of nice but not pretentious houses. The streets are kept clean and the houses are well cared for. It is known as a "nice place to live" but "society doesn't live here."

4. Average - These are areas of workingmen's homes which are small and unpretentious but neat in appearance. In these areas live "the respectable people in town who don't amount to much but never give anybody any trouble."

5. Below average - All the areas in this group are undesirable because they are close to factories, or because they include the business section of town, or are close to the railroad. There are more run-down houses here because there are people living in these areas who "don't know how to take care of things." They are more congested and heterogeneous than those above. It is said that "all kinds of people live here, and you don't know who your neighbors will be."

6. Low - These areas are run-down and semi-slums. The houses are set close together. The streets and yards are often filled with debris, and in some of the smaller towns, like Jonesville, some of the streets are not paved.

7. Very low - Slum districts, the areas with the poorest reputation in town, not only because of unpleasant and unhealthy geographical positions - for example, being near a garbage dump or a swamp - but also because of the social stigma attached to those who live there. The houses are little better than shacks. The people are referred to by such terms as "squatters along the canal," and are said to be lazy, shiftless, ignorant, and immoral. This general reputation is assigned to most people living in such sections regardless of their abilities or accomplishments.

Source of Income (3)

Rating 1. Inherited wealth. Familes were so classified who lived on money made by a previous generation. This includes money derived from savings and investments or business enterprises inherited from an earlier generation. Inherited wealth is frequently referred to as "old money" in contrast to "new money." This source of income has the highest prestige since it implies that there has been money in the family for several generations.

2. Earned wealth - Families or individuals were so classified if they lived on savings or investments earned by the present generation. This category implies considerable wealth, for the individual lives on interest from capital and has amassed sufficient money so that he does not need

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(2) Ibid., pp. 153-154.
(3) Ibid., pp. 138-142.

to work. This source of income applies most frequently to men who have made a large amount of money and are able to retire and live comfortably on their earnings. They differ from individuals who are retired because of old age and live on pensions, etc. In the present case, it is not that they are too old to work, but that they no longer need to work. One gains prestige in American society by being a successful business man and making a large fortune. Therefore, these individuals are given a higher rating than those who work for a living.

Rating 3. Profits and fees - This includes money which is paid to professional men for services and advice. It also includes money made by owners of business for sale of goods and royalties paid to writers, musicians, etc.

4. Salary - This is a regular income paid for services on a monthly, or yearly basis. This category also includes the commission type of salary paid to salesmen.

5. Wages - This is distinguished from salary since the amount is determined by an hourly rate. It is usually paid on a daily or weekly basis.

6. Private Relief - This includes money paid by friends or relatives for the sake of friendship or because of family ties. It also includes money given by churches, associations, etc., when the agency does not reveal the names of those getting help. People receiving this form of income usually have no money themselves and only through this help are saved the shame of asking for public relief.

7. Public relief and non-respectable income - This includes money received from a government agency or from some semi-public charity organization which does not mind revealing the names of those getting help. A non-respectable income includes money made from illegal occupation as gambling, prostitution, and bootlegging (during prohibition).

Revised Scale for Rating Occupation(4)

Occupation Rating	Professionals	Proprietors & Managers	Business Men	Clerks and Kindred Workers	Manual Workers	Protective and Service Workers	Farmers
1	Lawyers, doctors, dentists, engineers, judges, high-school superintendents, veterinarians, ministers (graduated from divinity school), chemists, etc. with post-grad. training, architects	Businesses valued at $75,000 and over	Regional and divisional managers of large financial and industrial enterprises	Certified Public Accountants			Gentlemen Farmers
2	High school teachers, trained nurses, chiropodists, chiropractors, undertakers, ministers (some training) newspaper editors, librarians(graduate)	Businesses valued at $20,000 and over	Assistant managers and office and department managers of large business, assistants to executives, etc.	Accountants, Salesmen of real estate, of insurance, postmasters			Large farm owners, farm owners
3	Social workers, grade-school teachers, optometrists, librarians (not graduate), undertaker's assistants, ministers (no training)	Businesses valued at $5,000 to $20,000	All minor officials of business	Auto salesmen, bank clerks and cashiers, postal clerks, secretaries to executives, supervisors of railroad, telephone, etc., justices of the peace	Contractors		

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(4) Ibid., pp.140-141.

Revised Scale for Rating Occupation - continued

4	Businesses valued at $2,000 to $5,000	Stenographers, bookkeepers, rural mail clerks, railroad ticket agents, sales people in dry good store	Factory foremen, electricians, plumbers, carpenters, watch makers (own business)	Dry cleaners, butchers, sheriffs, railroad engineers and conductors	
5	Businesses valued at $500 to $2,000	Dime store clerks, hardware salesmen, beauty operators telephone operators	Carpenters, plumbers, electricians (apprentice), timekeepers, linemen, telephone or telegraph, radio repairmen, medium-skill workers	Barbers, firemen, butcher's apprentice, practical nurse, policemen, seamstress, cook in restaurant, bartenders	Tenant farmers
6	Businesses valued at less than $500		Moulders, semi-skilled workers, assistants to carpenters, etc.	Baggage men, night policemen and watchmen, taxi and truck drivers, gas station attendants, waitresses in restaurant	Small tenant farmers
7			Heavy labor, migrant work, odd-job men, miners	Janitors, scrub women, newsboys	Migrant farm laborers

PSYCHOLOGIST'S TESTING SCHEDULE AND OBSERVATION CRITERIA

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2. Criteria for Significant Behavior in the Test Setting 36

PSYCHOLOGIST'S TESTING SCHEDULE AND QUALITATIVE JUDGMENTS

Name ______________________ School ______________________

Age ____ Grade ______

Sex ____

WISC

A. Sub-tests

Raw Score	Scaled Score	
______	______	Information
______	______	Comprehension
______	______	Similarities
______	______	Picture Completion
______	______	Block Design

B. Intellectural Functioning

______ est. Verbal IQ
______ est. Perf. IQ
______ Discrepancy between V and P IQ
______ est. Full scale IQ

BENDER

Design Errors:

____ Number of rotations
____ Number of distortions
____ Number of drawings with curve or angle difficulties
____ Number of drawings with immature response
____ Number of drawings with detachment
____ Number of drawings with perseveration
____ Number of drawings with incompleteness
____ Uneven figure size
____ Collision
____ Boxed figures
____ Crossing out
____ Starting over

Spacing on page:

____ Extreme top, bottom, or side
____ Regular
____ Expansions
____ Random
____ Multiple pages

Psychologist's Testing Schedule and Qualitative Judgments - continued

RORSCHACH

______ Number of responses

______ Average time per response

(Code: 0 = absent, 1-9 = frequency, 9+ = over 9)

LOCATION - List frequency of main responses.

______ W
______ D
______ d
______ Dd,S

DETERMINANTS - List frequency of:

1. Movement

______ M
______ M additional
______ FM
______ FM additional
______ m
______ m additional

2. Vista, depth

______ k
______ K
______ FK
______ Additional (k, K, FK)

3. Form

______ F
______ F-
______ F vogue
______ Additional (F, F-, F vogue)

4. Texture, achromatic color

______ Fc
______ cF
______ C'
______ Additional (Fc, cF, C')

5. Color

______ FC
______ Additional (FC)
______ CF
______ Additional (CF)
______ C
______ Additional (C)

CONTENT - List frequency of main responses.

______ H
______ Hd
______ At
______ A
______ Ad
______ Nature, Landscape, Plants
______ Fire
______ Water
______ Clothing
______ Object
______ Clouds
______ Architecture
______ Other, list ______________
______ Populars

Psychologist's Testing Schedule and Qualitative Judgments - continued

Code: 0 = absent
1 = present
2 = present to marked degree

CLINICAL IMPRESSION

______ Cooperative
______ Good control
______ Good frustration tolerance
______ Conforming behavior
______ Relaxed

ATTITUDES TOWARD EXAMINER

______ Shyness
______ Brashness
______ Need to impress

______ Over friendliness
______ Dependency
______ Defensiveness

ATTITUDES TOWARD TEST AND TEST MATERIALS

______ Over-impulsivity
______ Over-deliberateness
______ Giving up
______ Persistence
______ Over-reactions to success and/or failure
______ Attention and concentration difficulties
______ Intellectualization
______ Personal reference
______ Irreality elements
______ Free association
______ Blocking

QUALITATIVE JUDGMENTS

Make tentative judgment on a rating scale of 1 - 5, excellent adjustment to very poor.

______ 1. Does this pupil have poor intellectual functioning?
______ 2. Is there evidence of severe perceptual difficulties?
______ 3. Does the Rorschach indicate a pupil with severe personality disturbances?
______ 4. Does this child have problems relating to his classroom teacher?
______ 5. Does this child meet learning tasks effectively?
______ 6. Does this child have creative potential?
______ 7. Does this child have poor school adjustment?
______ 8. Does this child have poor school achievement?
______ 9. Overall WISC rating
______ 10. Overall Bender rating
______ 11. Overall Rorschach rating

Criteria for Significant Behavior in the Test Setting*

A. Attitudes toward the Examiner - Interpersonal Relationships

1. Shyness - Shyness can be presumed to be the child's holding back from responding to the examiner, even after a period of getting acquainted. A certain degree of reserve, especially in the initial period of contact is a normal sign in school age children and, in fact, should be expected as an indication of good adjustment. However, when it persists to the point of limited responses, problems are indicated.

2. Brashness - The child's approach to the examining situation and the examiner may be brash or even aggressive when behavior is directed against the material, the examiner, or both. Grabbing material, bending or drawing on the cards, tossing things roughly on the table, all suggest notably uncontrolled behavior which can be expected in other settings as well. Impertinent questioning of the examiner ("you tell me the answer"), refusal to remain seated during the test, answering back, and other such inappropriate reactions indicate an inability to restrain behavior and a tendency to act out negative feelings.

3. Need to Impress - A child stresses his ability, derides the difficulty of items, insists on his own adequacy. Excesses in this direction indicate insecurity, and can be used as a measure of the degree to which the child must utilize the denial of inadequacy to get along.

4. Over-friendliness - An overly friendly approach to the examiner is atypical of the school age child. The child who treats the examiner as an equal (for example, reversing the questioning) may be unacceptable in the classroom for the same reason. This can indicate an inability to accept authority and the appropriate role of the pupil, or perhaps a too-frantic seeking for contact.

5. Dependency - A role frequently reflecting simple immaturity or retardation, but often indicating emotional problems as well. This presents a sharp contrast to the self-reliant and independent behavior expected at different age levels. Such a child calls out for constant reassurance, or presents each response hesitantly or interrogatively, waits for approval before daring to continue. A lack of initiative in active participation in the examination such as returning material independently, once the examination is underway, suggests passivity, immaturity and possible anxiety relating to authority.

6. Defensiveness - Another valuable clue in attitudes toward learning is a characteristic attitude of defensiveness which may be elicited often by the test situation. For example, the child can reveal an on-guard, apprehensive, expecting-the-worst pattern of behavior, as compared to an attitude of relaxation and spontaneity.

B. Attitudes toward the Test and Test Materials

1. Impulsivity - An overly impulsive approach to material may be revealed by the child's blurting out responses without due consideration, or manipulating objects with no prior consideration of their meaning. This is characteristic of the very young child; in children eight years and older, it indicates immaturity or regression. It may also indicate a deliberate avoidance of preliminary reflection, perhaps because such delay would allow the child to become aware of his feelings, which are highly anxiety-arousing.

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* Glasser, A. J. and Zimmerman, Lee, Projective Aspects of the WISC. presented at the Calif. State Psychological Association conference, San Francisco, 1961.

2. **Deliberateness** - An opposite of impulsiveness is deliberateness. When this approach is used to an extreme, the child may ponder endlessly before hazarding a response. This behavior is penalized heavily on timed items, and it is important to note failures due primarily to this defensive behavior. It shades into obsessive and ambivalent doubting, and may be a forerunner of a serious personality problem. Perfectionism can be revealed in this way and prove to be an important lead to school difficulties.

3. **Giving up** - When the child gives up the struggle to succeed readily, rejecting even easy problems as "too hard", significant problems in learning are indicated. It may mean a low level of aspiration typical of the non-achiever, or real uncertainty about his own abilities. Specific neurological difficulties sometimes cause a child to be unable to judge his own skills accurately, especially when his abilities tend to be erratic.

4. **Persistence** - The reverse of giving up can be found in the child's persisting to attempt to solve problems. The persistence may be organized and realistic or blind and perseverative. Some children insist on working problems beyond their ability in a somewhat driven manner. The willingness to accept one's limitations can be of great importance in the classroom, which requires the acceptance of a state of ignorance in order to acquire learning. Persistence can be a clue to the ability or inability of a youngster to organize activities within the time limits which are culturally imposed.

5. **Reactions to success and failure** - It is important to observe the child's reaction to the product of his work, or to success and to failure. Some children cannot accept the examiner's praise or approval, become uncomfortable, and drive themselves to further effort. Thus, success is discounted as unimportant, the items are "too easy." The child's inability to accept his own skills suggests a driving conscience (or parent) taking the enjoyment out of learning by constantly raising the level of aspiration, giving the child no chance to rest on his laurels. An overzealous drive for achievement often arises from this setting.

6. **Attention and concentration** - Attention is an important variable measured by the WISC, both in its formal aspects by the subtests and in general test behavior. Is attention adequate, or does it wander readily? Irrelevant material introjected into the examination may indicate the child's vulnerability to any stimuli and inability to screen out unrelated material. Giving up indicates the inability to sustain attention for sufficient period of time to succeed. It is of value to note not only the extent of attention span, but also its timing and the areas where it is most vulnerable.

7. **Intellectualization** - When answers are pedantic and overly extended, with all possible aspects covered (Information: Discover America? "Some people say Christopher Columbus in 1492, but Leif Erickson came to America before that, and the Vikings came to Greenland, and . . ."), it may indicate the need to be in control of "dangerous situations" by use of the intellect, with a corresponding fear of or rejection of feelings and emotions. Since the WISC subtests assume some ability to bypass the emotions, this test style should be carefully evaluated to determine what is extreme or inappropriate intellectualization. Can emotion be successfully controlled in the interest of impersonal learning? Also, note at what point the child appears to view the test situation as requiring such a careful response. The need to be right, to avoid any presumably trick aspects by covering everything, suggests that intellectual matters have a threatening quality. A suggested hypothesis stemming from this is that in the classroom the child feels threatened, and therefore displays fearful feelings and emotions in such a situation. The attempt to give all possible answers in order to avoid being wrong can reach the extreme of obsessive preoccupation, with all sorts of alternatives introduced, indicating the extent of doubting and ambivalence characterizing the child's thinking.

8. Personal Reference - When test material persistently elicits some reference to the child's own life and activities, pressing problems are implied (Comprehension 1: Cut your finger. "Go to the hospital. I went to the hospital for my tonsils.") This suggests an inappropriate degree of self-centeredness, typically seen in an immature personality or a child who is unable to act in an age-adequate manner. It is brought out in two ways: one, a pervasive flooding of personal material throughout the test; and second, an unwarranted insertion of personal material in a specific area, suggesting that disturbances are limited to this aspect alone. Comprehension items may trigger such responses by their hostile or guilt-arousing nature. An entire subtest which is handled with great difficulty may also illustrate the same problem. The pre-examination period of establishing rapport is very important in ascertaining the child's present realistic concerns. For example, just before being examined, a child had seen a youngster badly cut in a fall on the playground. He indicated his immediate preoccupation with this incident in the initial conversation, and again on the Comprehension item. No other references of a personal nature occurred, and the child was correctly classified as well adjusted (Emotionally Disturbed Children Research).

9. Reality-Oriented Task Completion (Irreality Elements) - Functioning at a reality-oriented level can readily be estimated from WISC responses. Withdrawn, fantasy-oriented responses fall into a broad category, the range of which can be judged by the type and quality of free associations, as well as by many aspects of attention, concentration, ability to plan, and perception of detail. Reality ties (in this case, how he handles the task) are an important means of measuring a child's ability to adjust to his school situation. When fantasy or inner needs become so satisfying and important as to push out real life, the child's adjustment is tenuous, and a serious problem exists.

10. Free Association - Even more significant than occasional personal reference is the tendency to free association. This often overlaps with personal reference, in that irrelevant data is scattered through the protocol, perhaps revealing the child's current concerns, or merely his inability to reject non-pertinent stimuli around him (Information: "Seven days in a week. I have a red dress like those flowers."). Only very young children should be expected to elaborate their responses with a flood of loosely associated ideas. The limited attention span and immaturity implied by this are important findings. Sometimes bizarre interjections point up clearly the presence of serious personality problems. (Comprehension, Train Item: "I would tell someone. The train would run over somebody, they would get killed, everybody would be killed, my brother is in the hospital.")

11. Blocking - When the child blocks in his responses with, "I don't know", a frequent answer even at the simplest level, the unwillingness to hazard an answer suggests either a perfectionistic self standard, little interest, or lack of emotional energy for use in intellectual tasks. In the latter case, repression has played too great a part in personality development. To clarify which personality variable is affected here, praise and encouragement are of importance. An answer which is readily elicited after encouragement has not apparently been adversely affected by the repressive process.

Scoring Criteria for Bender

Design Error	Criteria
Number of rotations	Revolving of the total figure on its axis in either clockwise or counter-clockwise direction such that the angle subtended between the figure's horizontal axis and horizontal edge of the paper is more than 15° greater than that in the standard stimulus figures.
Number of distortions	Destruction of the Gestalt and/or extreme deviation from the stimulus figure.
Number of drawings with curve or angle difficulties	Possible modifications include: pointing curved subparts, flattening curved subparts, scalloping or uneven amplitude.
Number of drawings with immature response	Regression or lack of maturation is the use of less mature concepts in figure reproductions. The following deviations must be present in 3 or more units of the figure: 1) circles, dashes, commas, or scribble for dots or loops; 2) dots for loops; 3) arcs instead of clear cut angles in # 3.
Number of drawings with detachments	Detachment refers to the reproduction without overlap of the connected contour of the whole figure or any subpart. Included also is the joining of subparts. Difficulty in closing may result in the following deviations: break in contour, runover at point of juncture; separation of subparts.
Number of drawings with perseveration	Increase in the number of units as compared with the stimulus. The general gestalt may be accurately reproduced, but the number of units comprising the whole is incorrect. An error of 2 or more units is necessary in order to consider the figure deviant in this respect.
Number of drawings with incompleteness	Incompleteness or truncation of units as compared with the stimulus. The general gestalt may be accurately reproduced, but the number of units comprising the whole is incorrect; an error of 2 or more units is necessary in order to consider the figure deviant in this respect.
Uneven figure size	One or more extremely large or small figure in comparison with the remainder of the drawings.
Collision	Penetration of one subpart by another; displacement of subpart; and absorption by one subpart of the apex of another and overlap in reproductions of drawings.
Boxed figures	
Crossing out	
Starting over	

Scoring Criteria for Bender - continued

Spacing on Page	Criteria
Organization (top, bottom, or side)	Extreme top, bottom, or side. Two-thirds or more of the figures are contained within the top, bottom, or side one-third of the page when the paper is in vertical position, or contained within the top or bottom ½ of a page oriented horizontally.
Regular	All figures drawn so as to follow a direct sequence on the page in either a horizontal or vertical direction. Placement of the drawings appear forced and without consideration of size or shape.
Expansions	The figures are spread widely on page or pages with a considerable amount of separation of figures.
Random spacing	No particular order.
Multiple pages	More than one page or more than one side of a page used.

PSYCHIATRIST'S INTERVIEW SCHEDULE

Name ____________________ Age ____ Sex ____ School ______________ Date ________

Child's Understanding of Why He is Being Seen*

(Why does the child think he came to the office for an interview?)

______ 0. Child says he doesn't know why.
______ 1. Child's explanation is reasonably correct.
______ 2. Child's explanation is partially correct, but is limited or distorted.
______ 3. Child's explanation is totally erroneous.
______ 8. Other
______ 9. Insufficient data

General Physical Health*

______ 0. Appears entirely healthy
______ 1. Imperfect health - State: ____________________
______ 9. Insufficient data

Description of Body Build*

(Check all appropriate numbers)

______ 0. Tall for age
______ 1. Short for age
______ 2. Average height for age
______ 3. Obese
______ 4. Thin
______ 5. Medium build
______ 8. Other - State: ____________________
______ 9. Insufficient data

Grooming and Dress*

______ 0. Appropriate
______ 1. Unusual or inappropriate - Describe: ________________
______ 9. Insufficient data

Unusual Physical Characteristics*

(i.e. deformities, severe acne, dental deformities, amputation. Note especially any facial defect or disfigurement.)

______ 0. Absent
______ 1. Present - Describe briefly: ____________________
______ 9. Insufficient data

Physically Active vs. Physically Passive*

______ 0. Physically hyperactive
______ 1. Not unusually hyperactive or physically passive
______ 2. Physically passive
______ 8. Other
______ 9. Insufficient data

Chronic Anger or Resentment*

_____ 0. Much anger and resentment demonstrated
_____ 1. Little to moderate amount demonstrated
_____ 2. None observable
_____ 8. Other - State: _______________
_____ 9. Insufficient data

Sexual Identification*
(as judged by behavior and attitudes)

_____ 0. Behavior and attitudes suggesting inappropriate sexual identification
_____ 1. Behavior and attitudes suggesting both appropriate and inappropriate sexual identification
_____ 2. Behavior and attitudes suggesting appropriate sexual identification
_____ 8. Other
_____ 9. Insufficient data

Speech Maturity*

_____ 0. Advanced for age
_____ 1. Not unusually advanced or retarded for age
_____ 2. Retarded for age
_____ 8. Other - State: _______________
_____ 9. Insufficient data

Speech Difficulty**

_____ 0. Immature speech
_____ 1. Retarded speech development
_____ 2. Failure of speech to develop without intellectual or motor failure
_____ 3. Stuttering
_____ 4. Articulation difficulty
_____ 5. Speech regression
_____ 6. Bizarre speech (i.e. neologisms, self-made language, etc.)
_____ 8. Lisp

Child's Skill at Verbalizing*

_____ 0. Not at all
_____ 1. Talks about things in an indirect or restricted way
_____ 2. Talks freely
_____ 8. Other - State: _______________
_____ 9. Insufficient data

Gross and Seriously Deviant Behavior**

_____ 0. Strange behavior
_____ 1. Withdrawn or seclusive
_____ 2. Delusions
_____ 3. Hallucinations
_____ 4. Illogical or strange thinking
_____ 5. Inappropriate emotions
_____ 6. Suicidal ideation
_____ 8. Severe regression or developmental failure without physical cause

Dominant Affect or Mood*

______ 0. Anger
______ 1. Depression
______ 2. Elation
______ 3. Fearfulness
______ 4. Withdrawal
______ 5. Indifference
______ 6. Anxiety
______ 7. Irritability
______ 8. Other - State: ______
______ 9. Insufficient data

"Grown-up" vs. "Childish" Behavior**

______ 0. Excessively "grown-up" for age
______ 1. Neither unusually "grown-up" nor "childish"
______ 2. Excessively "childish" for age
______ 8. Other - State: ______
______ 9. Insufficient data

Obedience vs. Rebelliousness**

______ 0. Overly obedient
______ 1. Not unusually obedient or rebellious
______ 2. Moderate rebellion
______ 3. Extremely rebellious
______ 9. Insufficient data

Child's Reaction to Interviewer*

(How would you characterize the child's relationship with you at the end of the evaluation?)

______ 0. Strongly positive
______ 1. Slightly positive
______ 2. Neutral reaction
______ 3. Slightly negative
______ 4. Strongly negative
______ 8. Other - State: ______
______ 9. Insufficient data

Interviewer's Personal Reaction to Child*

______ 0. Strongly positive
______ 1. Slightly positive
______ 2. Neutral reaction
______ 3. Slightly negative
______ 4. Strongly negative
______ 8. Other - Specify: ______
______ 9. Insufficient data

Clinical Estimate of Child's Intelligence*

______ 0. Above average
______ 1. Within average range
______ 2. Below average
______ 8. Other - State: ______
______ 9. Insufficient data

Estimate of Current Scholastic Achievement in Basic Subjects**

______ 0. Does not attend school
______ 1. Outstanding
______ 2. Very good
______ 3. Average
______ 4. Poor
______ 5. Failing
______ 6. Erratic and inconsistent
______ 8. Other - State: ______
______ 9. Insufficient data

Overall Confidence in Data Obtained*

______ 0. Very accurate
______ 1. Fairly accurate
______ 2. Probably accurate in many instances
______ 3. Grossly inaccurate
______ 9. Insufficient data

Estimate of Child's Capacity for Psychological Improvement*

______ 0. Very great
______ 1. Moderate
______ 2. Minimal
______ 3. None
______ 8. Other - State: ______________
______ 9. Insufficient data

Observable Symptoms

______ Nail biting
______ Tics
______ Speech disorders
______ Posture
______ Mannerisms
______ Compulsivity
______ Fearfulness

______ Awkwardness
______ Hyperactivity
______ Restlessness
______ Distractibility
______ Impaired attention
______ Accident proneness
______ Thumbsucking
______

Impression of Child

(Make tentative judgment on a rating scale of 1 - 5)(excellent to very poor)

______ 1. Is this child comfortable with himself?

______ 2. Is this child comfortable with others?

______ 3. Is this a child with serious learning difficulties?

______ 4. Is this a child with serious behavior problems?

______ 5. Does this child need help?

______ 6. Does this child have appropriate contact with and relationship to reality?

______ 7. Is this a child with generally poor school adjustment?

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* Psychiatry Project A Form 1C
** Psychiatry Project A Form 1B
Prepared by the Department of Psychiatry, University of California at Los Angeles, 1959

PROCEDURE FOR QUALITATIVE JUDGMENTS

Page

1. Procedures for Qualitative Ratings of Pupils by Clinical Teams 46
2. Sample Social Worker Qualitative Judgment Booklet 47
3. Final Rating of Overall School Adjustment 56

Procedures for Qualitative Ratings of Pupils by Clinical Teams

The following material contains a sample booklet illustrating the procedures for qualitative judgments by each clinical group. The social worker's qualitative judgment booklet is used for a sample. The booklet for psychologists and psychiatrists is comparable except for slight modifications in instructions and different qualitative judgments. The qualitative judgments for each clinical group are as follows:

A. Social Worker's Qualitative Judgments

1. This child has serious physical problems (handicaps, psychosomatic disorders, general health problems).
2. This child's development has shown deviant psychological patterns (deprivation, rejection, hostility, etc.).
3. The social environment (housing, neighborhood, cultural values of family, peer relations, etc.) in which the child lives has been conducive to poor development.
4. This is a family which would produce a child with serious learning and behavior problems.
5. This child has serious personality problems.
6. This child has school adjustment problems.
7. This child has school learning problems.

B. Psychologist's Qualitative Judgments

1. This child has poor intellectual functioning.
2. There is evidence of severe perceptual difficulties.
3. The Rorschach indicates a pupil with severe personality disturbances.
4. This child has problems relating to his classroom teacher.
5. This child meets learning tasks effectively.
6. This child has creative potential.
7. This child has poor school adjustment.
8. This child has poor school achievement.
9. Overall rating of WISC test.
10. Overall rating of Bender test.
11. Overall rating of Rorschach test.

C. Psychiatrist's Qualitative Judgments

1. This child is comfortable with himself.
2. This child is comfortable with others.
3. This is a child with serious learning difficulties.
4. This is a child with serious behavior problems.
5. This child needs help.
6. This child has appropriate contact with and relationship to reality.
7. This is a child with generally poor school adjustment.

SOCIAL WORKERS QUALITATIVE JUDGMENTS

Name of Social Worker ____________________ Grade ____________________

Date of This Rating ____________________ Schools ____________________

This folder has room for making qualitative judgments of forty pupils on each of the situational characteristics which social workers can judge as being predictive of a pupil with poor adjustment in school. You may use this folder once you have interviewed at least ten families. Names can be added as you continue your interviews. It is expected that your criteria for positive and negative judgments will be changing as you continue to interview families, so you may revise this rating as many times as you wish in order to make your judgments as consistent as possible. Complete as many of these as you wish, but keep all of your ratings so we can preserve your thinking.

First write in the name of each pupil whose parent you have interviewed at the right of the folder. Keep one folder for second grade pupils and one folder for fifth grade pupils. Follow the instructions below for completing the qualitative judgments.

Your rating job is to locate every child whose parent you have interviewed on a scale that runs from "best adjusted" (1) to "poorest adjusted" (5) and place their names on the grid as you feel they fall into either of these extremes or into columns in between. Keep track of the characteristics which you used for making a judgment of 1 to 5 so that you can compare your work with other social workers.

From the group you have interviewed pick two situations with the characteristics which were most predictive of poor adjustment on the quality which you are rating and write their names in the first two boxes in column 5. Next pick two pupils from those whose parents you have interviewed who had characteristics which were most predictive of pupils with good adjustment and write their names in the first two boxes in column 1.

Now return to your list of names and identify from the remaining pupils those who might be poorly adjusted, but with fewer negative characteristics than those in column 5 and write their names in the first two boxes in column 4. Do the same for column 2 finding from your list two pupils who might be not so well adjusted as those in column 1, but still on the positive side of the continuum. Finally, locate two pupils who were in between the good and poorly adjusted pupils and place their names in column 3.

When you have completed the rating of ten pupils from your list, you may place the names of those pupils who remain in columns appropriate to the criteria you have used in locating the first ten names. You do not need to feel that there should be an equal number in each column. Characteristics of the population you have seen will account for some skewing of your ratings. The sampling which was used may account for skewing also. In any case, continue writing in names of pupils for the grid until each pupil has been given a rating. Follow this procedure for all the qualitative ratings.

You will have made notes of the criteria which were used in placing pupils in columns 1 and 5 as you worked along. Review these criteria and in the spaces under columns 1, 3 and 5 list adjectives which seem to best describe those pupils who are in that column. This material will then be compared to that provided by other social workers and at the completion of all the ratings, we should be able to produce the general criteria which were used for each qualitative judgment.

Most positive 1	2	3	4	Most negative 5

Criteria: ______ ______ ______

Criteria: ______ ______ ______

Criteria: ______ ______ ______

1. This child has serious physical problems (handicaps, psychosomatic disorders, general health problems).

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←

Most positive 1	2	3	4	Most negative 5

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←

Criteria:	Criteria:	Criteria:
__________	__________	__________
__________	__________	__________
__________	__________	__________

2. This child's development has shown deviant psychological patterns (deprivation, rejection, hostility, etc.).

1 Most positive	2	3	4	5 Most negative

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←

Criteria:

____
____
____

Criteria:

____
____
____

Criteria:

____
____
____

3. The social environment (housing, neighborhood, cultural values of family, peer relationships, etc.) in which the child lives has been conducive to poor development.

1 Most positive	2	3	4	5 Most negative

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Criteria:

Criteria:

Criteria:

4. This is a family which would produce a child with serious learning and behavior problems.

1 Most positive	2	3	4	5 Most Negative

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Criteria:	Criteria:	Criteria:
___	___	___
___	___	___
___	___	___

5. This child has serious personality problems.

1 Most positive	2	3	4	5 Most negative

Please cut off this section of page to the dotted line.

Criteria:	Criteria:	Criteria:
______	______	______
______	______	______
______	______	______

6. This child has school adjustment problems.

1 Most positive	2	3	4	5 Most negative

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Criteria:

____
____
____

Criteria:

____
____
____

Criteria:

____
____
____

7. This child has school learning problems.

Total Score	Qualitative Judgment							Pupil's Name	Sex
	1	2	3	4	5	6	7		

Final Rating of Overall School Adjustment

Clinical Team:

Social Worker-Psychologist-Psychiatrist

Use the same procedure in completing the ratings of "Overall Rating of School Adjustment" as you used in rating the first set of qualitative judgments. Criteria for this rating are enclosed in this booklet. These criteria are the same ones used by the teachers in making the original judgments on your cases prior to the sampling.

To simplify your job, you can use the number opposite the pupil's name to place in the squares. This number is the same on both the final listing of all ratings and the list of names for final rating.

Only one distribution on a rating grid is needed - that of the distribution of pupils on your estimate of their overall school adjustment.

You will note that most of your ratings agree pretty well with the ratings made of the same pupil by the other clinicians. You do not need to change your rating of school adjustment from the one which you originally made unless you feel that the additional information added judgments which cause you to alter your original impression.

The other three final judgments do not need to be distributed on a rating grid. To judge these categories, use the following coding system and place the appropriate code in the square after each child's name on the final judgment sheet.

The final judgment codes to be used for item 1-3 are:

1. Is this a troubled or troublesome child?

   + = The child has no apparent problems.

   ? = The child might have problems but you're not sure.

   - = The child is probably troubled or troublesome.

2. Does this child need referral for psychotherapy?

   + = Probably not

   ? = Possibly, or not sure

   - = Yes

3. What is this child's ability to manage his life in the future?

   + = Probably good

   ? = Not sure

   - = Probably poor

Teacher Criteria for Rating School Adjustment

Most children who go to school are able to get along fairly well in learning tasks and are able to have rewarding experiences with peers and adults. The child who adjusts well to school is one who learns from his experiences; one who is able to spend his time on a variety of activities; one who has the ability to undergo stressful experiences without collapsing emotionally; one who is physically healthy; and one who is enthusiastic about life in general. The child who adjusts well is one of the majority of children in school and while he may or may not be the best student in class, he can be described as one who can exercise a variety of choices in his behavior and is comfortable with such freedom.

One can judge the extent to which a child can adjust to life and school from the degrees of freedom he has in choosing from among alternative kinds of behavior. Often one can infer a rigidity in a child's personality which causes him to have learning or behavior problems not amenable to ordinary corrective measures. Such limitations also serve to reduce the child's relative freedom of choice in other social and educational endeavors. The reduction of personal maneuverability and flexibility increases the child's difficulties in adapting to the pressures and changes in life. As a result, the child with emotional handicaps shows increasing susceptibility to behavioral difficulties and interpersonal friction.

Specifically, the child with poor school adjustment is defined as having moderate to marked reduction in behavioral freedom, which in turn reduces his ability to function effectively in learning or working with others. In the classroom, this loss of freedom affects the child's educative and social experiences and results in a noticeable susceptibility to one or more of the following five patterns of behavior:

1. An inability to learn which cannot be adequately explained by intellectual, sensory, neurophysiological or general health factors.
2. An inability to build or maintain satisfactory interpersonal relationships with peers and teachers.
3. Inappropriate or immature types of behavior or feelings under normal circumstances.
4. A general pervasive mood of unhappiness or depression.
5. A tendency to develop physical symptoms, such as speech problems, pains or fears associated with personal or school problems.

To sum up, the significant patterns of behavior in children indicative of poor school adjustment are:

Inability to learn
Unsatisfactory interpersonal relationships
Inappropriate behavior
Unhappiness
Repetitive symptoms of illness after stress

Overall Rating of School Adjustment

Pupil's Name

Use procedures required in making qualitative judgments.

1.
2.
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31.
32.
33.
34.

Final Judgment Sheet

School ______ Grade ___ Team: ______ ______ ______

Social Worker Psychologist Psychiatrist

Final Judgments — Independent Qualitative Judgments

	Final Judgments				Psychiatrists							Psychologists											Social Workers						
	4	3	2	1	7	6	5	4	3	2	1	11	10	9	8	7	6	5	4	3	2	1	7	6	5	4	3	2	1
1.																													
2.																													
3.																													
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5.																													
6.																													
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Final Judgment

1. Is this a troubled or troublesome child?
2. Does this child need referral for psychotherapy?
3. Child's overall ability to manage life in the future
4. Overall rating of school adjustment.

Psychiatrists

1. Is comfortable with himself.
2. Is comfortable with others.
3. Has serious learning difficulties.
4. Has serious behavior problems.
5. This child needs help.
6. Has appropriate contact with and relationship to reality.
7. Generally poor school adjustment.

Psychologists

1. Poor intellectual functioning.
2. Severe perceptual difficulties.
3. Severe personality disturbances
4. Problems relating to classroom teacher.
5. Meets learning tasks effectively.
6. Has creative potential.
7. Has poor school adjustment.
8. Has poor school achievement.
9. Overall rating of WISC.
10. Overall rating of Bender.
11. Overall rating of Rorschach.

Social Workers

1. Serious physical problems.
2. Development shows deviant psychological patterns.
3. Social environment conducive to poor development.
4. Family might produce a child with serious learning and behavior problems.
5. Serious personality problems.
6. School adjustment problems.
7. School learning problems.

AN EXAMPLE OF LOCAL NEWSPAPER PUBLICITY
ABOUT THE PROJECT

La Vista Schools

Parent Interviews Termed Success

By Archie Shamblin

The La Vista School Districts parent interview program has been launched successfully, according to Mrs. Jeanella Helmgren, district psychologist.

The program, first of its kind to be conducted, is planned to determine what factors outside the school affects the learning procedure of the student.

"We have talked to the parents of eight children to date," Mrs. Helmgren said. "And all the interviews were suciessful."

The team of La Vista officials and county social workers plan to interview the parents of from 40 to 60 students by next May.

The program is part of a larger program being conducted by the California State Department of Education in conjunction with the Federal Health, Education and Welfare Dept.

La Vista Dist. is the only district in Northern California selected to participate in the initial stages of the far-reaching program.

"We were selected to perform this survey because the district has shown a particular interest in this field in the past," Mrs. Helmgren said.

The results of the survey will be used by the state to set up a screening device so that students in other schools may be classified more accurately.

Only the parents of second and fifth graders at Tennyson and Treeview Schools will be interviewed, Mrs. Heimgren said. And these parents are selected by chance.

"The fact that the parents of a particular child have been selected to participate in this program does not mean that child has problems," she said. "Nor does it mean that the student doesn't have problems."

After the parents have been interviewed, the student is then subjected to ability tests and interviewed by a psychiastrist. When the parent interviews and the student tests are completed, the information will be sent to the Department of Education where it will be used to construct a screening device.

The La Vista School District's portion of the program should pe completed by May of next year, Mrs. Helmgren said.

Any information on a student will pe given to the parents on request, she said.

"It must be made clear that we are not concerned with anything here but those factors that effects the child's ability to learn," Mrs. Helmgren said. "We are not a health agency."

"We are trying to find out why one child, with an I.Q. equal to that of another, cannot learn as quickly as the other."

State employes assisting Mrs. Helmgren with the program are Dr. Jean Stevenson Wright, psychiatrist, Dr. Kate Dorst, clinical psychologist, and Mrs. June McHenry, master social worker.

CONSULTATION — Looking over the latest results of the La Vista School District's parent-interview program are Mrs. June McHenry, master social worker of Oakland, and Mrs. Jeanella Helmgren, psychologist for the school district. La Vista was selected as the only district in Northern California to work with the state on the program.

The Daily Review
Hayward, California
January, 1962

PSYCHIATRISTS' OBSERVATIONS OF CHARACTERISTICS OF PUPILS JUDGED TO BE WELL AND POORLY ADJUSTED IN SCHOOL

TABLE 1

Psychiatrist Evaluation of Child's Grooming and Dress Compared with Consensus Clinical Judgment of Good and Poor School Adjustment

Grooming and Dress

	Appropriate	Unusual or Inappropriate	Total Number Interviewed
2nd Grade Girls Clinical Group			
1. Consensus Well Adjusted	14		14
2. Neither Well nor Poorly Adjusted	44	7	51
3. Consensus Poorly Adjusted	8	2	10
Total	66	9	75
2nd Grade Boys Clinical Group			
1. Consensus Well Adjusted	8	2	10
2. Neither Well nor Poorly Adjusted	43	6	49
3. Consensus Poorly Adjusted	14		14
Total	65	8	73
5th Grade Girls Clinical Group			
1. Consensus Well Adjusted	9	2	11
2. Neither Well nor Poorly Adjusted	33	8	41
3. Consensus Poorly Adjusted	3		3
Total	45	10	55
5th Grade Boys Clinical Group			
1. Consensus Well Adjusted	4	1	5
2. Neither Well nor Poorly Adjusted	62	9	71
3. Consensus Poorly Adjusted	18	1	19
Total	84	11	95

TABLE 2

Psychiatrist Evaluation of Presence of Unusual Physical Characteristics* Compared With Consensus Clinical Judgment of Good and Poor School Adjustment

	Unusual Physical Characteristics			
	Absent	Present	Not Observed	Total Number Interviewed
2nd Grade Girls Clinical Group				
1. Consensus Well Adjusted	13	1		14
2. Neither Well nor Poorly Adjusted	40	10	1	51
3. Consensus Poorly Adjusted	4	6		10
Total	57	17	1	75
2nd Grade Boys Clinical Group				
1. Consensus Well Adjusted	7	3		10
2. Neither Well nor Poorly Adjusted	37	12		49
3. Consensus Poorly Adjusted	12	2		14
Total	56	17	0	73
5th Grade Girls Clinical Group				
1. Consensus Well Adjusted	8	3		11
2. Neither Well nor Poorly Adjusted	25	16		41
3. Consensus Poorly Adjusted	1	1	1	3
Total	34	20	1	55
5th Grade Boys Clinical Group				
1. Consensus Well Adjusted	4	1		5
2. Neither Well nor Poorly Adjusted	51	20		71
3. Consensus Poorly Adjusted	12	6	1	19
Total	67	27	1	95

*Unusual physical characteristics defined as deformities, acne, dental deformities, amputations or any facial defect or disfigurement.

TABLE 3

Psychiatrist Evaluation of Physically Active vs Passive Behavior During Interview Compared With Consensus Clinical Judgment of Good or Poor School Adjustment

	Physically Hyperactive	Not Unusually Hyperactive or Passive	Physically Passive	Other	Insufficient Data	Total Number Interviewed
2nd Grade Girls Clinical Group						
1. Consensus Well Adjusted	0	13	0	1		14
2. Neither Well nor Poorly Adjusted	5	34	11	1		51
3. Consensus Poorly Adjusted	1	4	4	1		10
Total	6	51	15	3		75
2nd Grade Boys Clinical Group						
1. Consensus Well Adjusted	2	6	2			10
2. Neither Well nor Poorly Adjusted	13	29	6	1		49
3. Consensus Poorly Adjusted	2	8	4	0		14
Total	17	43	12	1		73
5th Grade Girls Clinical Group						
1. Consensus Well Adjusted	1	8	2			11
2. Neither Well nor Poorly Adjusted	1	29	9	1	1	41
3. Consensus Poorly Adjusted	0	2	1			3
Total	2	39	12	1	1	55
5th Grade Boys Clinical Group						
1. Consensus Well Adjusted	0	3	2			5
2. Neither Well nor Poorly Adjusted	9	42	15	2	1	69
3. Consensus Poorly Adjusted	3	11	4	1		19
Total	12	56	21	3	1	93

TABLE 4

Psychiatrist Evaluation of Child's Speech Maturity Compared With Consensus Clinical Judgment of Good and Poor School Adjustment

	Speech Maturity					
	Advanced For Age	Not Unusually Advanced or Retarded For Age	Retarded for Age	Other	Insufficient Data	Total Number Interviewed
2nd Grade Girls Clinical Group						
1. Consensus Well Adjusted	3	11				14
2. Neither Well nor Poorly Adjusted	11	33	2	1	4	51
3. Consensus Poorly Adjusted	3	4	3			10
Total	17	48	5	1	4	75
2nd Grade Boys Clinical Group						
1. Consensus Well Adjusted	5	4				9
2. Neither Well nor Poorly Adjusted	9	29	7	1	1	47
3. Consensus Poorly Adjusted	2	7	4	1		14
Total	16	40	11	2	1	70
5th Grade Girls Clinical Group						
1. Consensus Well Adjusted	3	7			1	11
2. Neither Well nor Poorly Adjusted	5	28	2		5	40
3. Consensus Poorly Adjusted	0	2				2
Total	8	37	2		6	53
5th Grade Boys Clinical Group						
1. Consensus Well Adjusted	2	3				5
2. Neither Well nor Poorly Adjusted	13	51	2	1	3	70
3. Consensus Poorly Adjusted	3	12	3		1	19
Total	18	66	5	1	4	94

TABLE 5

Psychiatrist Evaluation of "Grown-Up" or Childish Behavior Compared With Consensus Clinical Judgment of Good and Poor School Adjustment

	Excessively Grown-Up	Neither Grown-Up Nor Childish	Excessively Childish	Other	Insufficient Data	Total Number Interviewed
2nd Grade Girls Clinical Group						
1. Consensus Well Adjusted	1	13				14
2. Neither Well nor Poorly Adjusted	6	40	3	0	2	51
3. Consensus Poorly Adjusted	1	6	1	1	1	10
Total	8	59	4	1	3	61
2nd Grade Boys Clinical Group						
1. Consensus Well Adjusted	1	8	1			10
2. Neither Well Nor Poorly Adjusted	6	36	4	2		48
3. Consensus Poorly Adjusted	0	8	5	1		14
Total	7	52	10	3		72
5th Grade Girls Clinical Group						
1. Consensus Well Adjusted	2	9				11
2. Neither Well nor Poorly Adjusted	7	26	2	3	3	41
3. Consensus Poorly Adjusted	0	3				3
Total	9	38	2	3	3	55
5th Grade Boys Clinical Group						
1. Consensus Well Adjusted	1	4				5
2. Neither Well Nor Poorly Adjusted	14	50	0	3	4	71
3. Consensus Poorly Adjusted	1	13	4	1	0	19
Total	16	67	4	4	4	95

TABLE 6

Psychiatrist Evaluation of Obedient vs Rebellious Behavior in Child Compared With Consensus Clinical Evaluation of Good and Poor School Adjustment

	Overly Obedient	Not unusually obedient or rebellious	Moderate Rebellion	Extremely Rebellious	Insufficient Data	Total Number Interviewe
2nd Grade Girls Clinical Group						
1. Consensus Well Adjusted	0	14				14
2. Neither Well nor Poorly Adjusted	5	37	4		4	50
3. Consensus Poorly Adjusted	2	4	4			10
Total	7	55	8		4	74
2nd Grade Boys Clinical Group						
1. Consensus Well Adjusted	1	5	3	0	1	10
2. Neither Well nor Poorly Adjusted	5	39	3	1	1	49
3. Consensus Poorly Adjusted	3	8	3	0	0	14
Total	9	52	9	1	2	73
5th Grade Girls Clinical Group						
1. Consensus Well Adjusted	2	9				11
2. Neither Well nor Poorly Adjusted	7	26	5	2	1	41
3. Consensus Poorly Adjusted	0	3				3
Total	9	38	5	2	1	55
5th Grade Boys Clinical Group						
1. Consensus Well Adjusted	1	4				5
2. Neither Well nor Poorly Adjusted	9	50	10	1	1	71
3. Consensus Poorly Adjusted	4	12	3			19
Total	14	66	13	1	1	95

TABLE 7

Child's Reaction to Psychiatrist as Judged by the Psychiatrist Compared With Consensus Clinical Judgment of Good and Poor School Adjustment

	Strongly Positive	Slightly Positive	Neutral	Slightly Negative	Strongly Negative	Other	Insufficient Data	Total Number Interviewed
2nd Grade Girls Clinical Group								
1. Consensus Well Adjusted	3	9	1	1				14
2. Neither Well nor Poorly Adjusted	9	26	11	2		2	1	51
3. Consensus Poorly Adjusted	3	3	0	2	2			10
Total	15	38	12	5	2	2	1	75
2nd Grade Boys Clinical Group								
1. Consensus Well Adjusted	1	7	2					10
2. Neither Well nor Poorly Adjusted	12	14	19	1	2	1		49
3. Consensus Poorly Adjusted	3	5	5	1	0	0		14
Total	16	26	26	2	2	1	0	73
5th Grade Girls Clinical Group								
1. Consensus Well Adjusted	3	6	1				1	11
2. Neither Well nor Poorly Adjusted	5	19	10	4	2	1		41
3. Consensus Poorly Adjusted	0	2	1					3
Total	8	27	12	4	2	1	1	55
5th Grade Boys Clinical Group								
1. Consensus Well Adjusted	0	2	3					5
2. Neither Well nor Poorly Adjusted	10	31	20	6	3	1		71
3. Consensus Poorly Adjusted	4	5	3	5	1	1		19
Total	14	38	26	11	4	2		95

TABLE 8

Psychiatrist's Personal Reaction to Child
Compared With Consensus Clinical Judgment of Good and Poor School Adjustment

	Strongly Positive	Slightly Positive	Neutral	Slightly Negative	Strongly Negative	Other	Total Number Interviewed
2nd Grade Girls							
Clinical Group							
1. Consensus Well Adjusted	3	10	1				14
2. Neither Well nor Poorly Adjusted	9	26	12	3	1		51
3. Consensus Poorly Adjusted	0	6	3	0		1	10
Total	12	42	16	3	1	1	75
2nd Grade Boys							
Clinical Group							
1. Consensus Well Adjusted	5	5					10
2. Neither Well nor Poorly Adjusted	12	23	12	1	0	1	49
3. Consensus Poorly Adjusted	1	9	4				14
Total	18	37	16	1		1	73
5th Grade Girls							
Clinical Group							
1. Consensus Well Adjusted	3	6	2				11
2. Neither Well nor Poorly Adjusted	3	31	5	2			41
3. Consensus Poorly Adjusted	0		3				3
Total	6	37	10	2			55
5th Grade Boys							
Clinical Group							
1. Consensus Well Adjusted	0	3	2				5
2. Neither Well nor Poorly Adjusted	11	38	21	1			71
3. Consensus Poorly Adjusted	3	10	4	2			19
Total	14	51	27	3			95

TABLE 9

Total Number of Symptoms* Noted During Psychiatric Interview Compared With Consensus Clinical Judgment of Good and Poor School Adjustment

	Total Number of Symptoms										Total Number Interviewed
	0	1	2	3	4	5	6	7	8	9	
2nd Grade Girls Clinical Group											
1. Consensus Well Adjusted	9	4	1								14
2. Neither Well nor Poorly Adjusted	21	15	6	6	1	1		1			51
3. Consensus Poorly Adjusted	3	3	1		1		1		1		10
Total	33	22	8	6	2	1	1	1	1	0	75
2nd Grade Boys Clinical Group											
1. Consensus Well Adjusted	5	1	0	2	1	0	1				10
2. Neither Well nor Poorly Adjusted	23	7	5	6	6	1	0	1			49
3. Consensus Poorly Adjusted	4	5	2	0	0	1	1	0	1		14
Total	32	13	7	8	7	2	2	1	1	0	73
5th Grade Girls Clinical Group											
1. Consensus Well Adjusted	7	1	1	2							11
2. Neither Well nor Poorly Adjusted	13	13	7	3	2	2					40
3. Consensus Poorly Adjusted	2	1									3
Total	22	15	8	5	2	2					54
5th Grade Boys Clinical Group											
1. Consensus Well Adjusted	3	1	0	0	1						5
2. Neither Well nor Poorly Adjusted	21	21	15	6	3	3	1	0	1		71
3. Consensus Poorly Adjusted	5	9	1	2	0	0	1	0	0	1	19
Total	29	31	16	8	4	3	2	0	1	1	95

*Symptoms include tics, nail-biting, speech disorders, posture, mannerisms, fearfulness, awkwardness, hyperactivity, impaired attention, thumbsucking, etc.

TABLE 10

Psychiatrist's Confidence in Interview Data
Compared With Consensus Clinical Judgment of Good and Poor School Adjustment

	Very Accurate	Fairly Accurate	Probably Accurate In Many Instances	Grossly Inaccurate	Insufficient Data	Total Number Interviewed
2nd Grade Girls Clinical Group						
1. Consensus Well Adjusted	6	4	4			14
2. Neither Well nor Poorly Adjusted	7	24	19	1		51
3. Consensus Poorly Adjusted	2	3	4	0	1	10
Total	15	31	27	1	1	75
2nd Grade Boys Clinical Group						
1. Consensus Well Adjusted	2	5	3			10
2. Neither Well nor Poorly Adjusted	8	25	16			49
3. Consensus Poorly Adjusted	0	7	4	1	1	13
Total	10	37	23	1	1	72
5th Grade Girls Clinical Group						
1. Consensus Well Adjusted	6	4	1			11
2. Neither Well nor Poorly Adjusted	5	18	18			41
3. Consensus Poorly Adjusted	0	1	2			3
Total	11	23	21			55
5th Grade Boys Clinical Group						
1. Consensus Well Adjusted	1	3	1			5
2. Neither Well nor Poorly Adjusted	7	43	20	0	1	71
3. Consensus Poorly Adjusted	0	9	10			19
Total	8	55	31	0	1	95

PSYCHIATRISTS' OBSERVATIONS OF PUPIL CHARACTERISTICS COMPARED WITH ORIGINAL TEACHER RATING OF SCHOOL ADJUSTMENT

TABLE 11

Psychiatrists Judgment of Child's Grooming and Dress Compared with Original Teacher Rating of School Adjustment

Grooming and Dress

	Appropriate	Unusual or Inappropriate	Total Number Interviewed
2nd grade girls			
Original Teacher Rating			
1	3	1	4
2	5	3	8
3	21	2	23
4	8	0	8
5	13	2	15
6	10	0	10
7	6	1	7
Total	66	9	75
2nd grade boys			
Original Teacher Rating			
1	9	0	9
2	7	1	8
3	7	2	9
4	7	0	7
5	12	1	13
6	15	3	18
7	8	1	9
Total	65	8	73
5th grade girls			
Original Teacher Rating			
1	1	1	2
2	7	2	9
3	3	1	4
4	16	2	18
5	8	2	10
6	5	2	7
7	5	0	5
Total	45	10	55
5th grade boys			
Original Teacher Rating			
1	4	0	4
2	8	2	10
3	8	2	10
4	20	1	21
5	17	5	22
6	20	1	21
7	7	0	7
Total	84	11	95

TABLE 12

Psychiatrists Observation of Unusual Physical Characteristics of Child Compared With Original Teacher Rating of School Adjustment

	Unusual Physical Characteristics			
	Absent	Present	Insufficient Data	Total Number Interviewed
2nd grade girls				
Original Teacher Rating				
1	4			4
2	8			8
3	14	9		23
4	7	1		8
5	13	2		15
6	6	3	1	10
7	5	2		7
Total	57	17	1	75
2nd grade boys				
Original Teacher Rating				
1	6	3		9
2	7	1		8
3	8	1		9
4	4	3		7
5	11	2		13
6	14	4		18
7	6	3		9
Total	56	17		73
5th grade girls				
Original Teacher Rating				
1	1	1		2
2	6	3		9
3	3	1		4
4	11	7		18
5	8	2		10
6	2	4	1	7
7	3	2		5
Total	34	20	1	55
5th grade boys				
Original Teacher Rating				
1	4			4
2	6	4		10
3	8	2		10
4	14	7		21
5	12	9	1	22
6	18	3		21
7	5	2		7
Total	67	27	1	95

TABLE 13

Psychiatrist's Observation of Whether Child was Physically Active vs Physically Passive Compared With Original Teacher Rating of School Adjustment

	Physically Hyperactive	Neither Hyperactive Nor Passive	Physically Passive	Other	Insufficient Data	Total Number Interviewed
2nd grade girls						
Original Teacher Rating						
1	0	3	1			4
2	2	4	2			8
3	1	15	6	1		23
4	1	6	1			8
5	1	12	1	1		15
6	0	7	2	1		10
7	1	4	2			7
Total	6	51	15	3		75
2nd grade boys						
Original Teacher Rating						
1	1	6	2			9
2	3	5	0			8
3	3	4	2			9
4	2	4	1			7
5	0	9	3	1		13
6	4	10	4			18
7	4	5	0			9
Total	17	43	12	1		75
5th grade girls						
Original Teacher Rating						
1	1	1				2
2	0	8		1		9
3	0	3	1			4
4	0	12	6			18
5	1	6	3			10
6	0	6	1			7
7	0	3	1		1	5
Total	2	39	12	1	1	55
5th grade boys						
Original Teacher Rating						
1	0	2	2			4
2		7	2	1		10
3	0	6	3			9
4	2	11	6	1		20
5	3	13	6			22
6	4	14	1	1	1	21
7	3	3	1			7
Total	12	56	21	3	1	93

TABLE 14

Psychiatrist's Observation of Grown-Up vs Childish Behavior Compared With Original Teacher Rating of School Adjustment

	Excessively grown-up for age	Neither grown-up nor childish	Excessively childish for age	Other	Insufficient Data	Total Number Interviewed
2nd grade girls Original Teacher Rating						
1	2	2				4
2	3	4	1			8
3	1	19	2		1	23
4	0	8	0	0	0	8
5	0	14	0	0	1	15
6	2	6	0	1	1	10
7	0	6	1	0	0	7
Total	8	59	4	1	3	75
2nd grade boys Original Teacher Rating						
1	0	9				9
2	2	5	1			8
3	0	9	0			9
4	0	7				7
5	1	9	1	2		13
6	3	8	5	1		17
7	1	5	3			9
Total	7	52	10	3	0	72
5th grade girls Original Teacher Rating						
1	1	1				2
2	0	5	1	1	2	9
3	1	2			1	4
4	3	15				18
5	2	6	1	1		10
6	2	5				7
7	0	4		1		5
Total	9	38	2	3	3	55
5th grade boys Original Teacher Rating						
1	1	3				4
2	5	5				10
3	2	7			1	10
4	2	16	1		2	21
5	3	14	2	2	1	22
6	3	15	1	2		21
7	0	7				7
Total	16	67	4	4	4	95

TABLE 15

Psychiatrist's Observation of Obedient vs Rebellious Behavior of Child Compared With Original Teacher Rating of School Adjustment

	Overly Obedient	Not unusually obedient or rebellious	Moderate Rebellion	Extremely Rebellious	Insufficien Data	Total Numbe Intervi
2nd Grade Girls						
Original Teacher Rating						
1	0	4				4
2	0	5	1		2	8
3	3	18	1		1	23
4	0	7	0			7
5	1	13	1			15
6	2	4	3		1	10
7	1	4	2			7
Total	7	55	8		4	74
2nd Grade Boys						
Original Teacher Rating						
1	1	5	3			9
2	0	7	0		1	8
3	0	8	1			9
4	0	7	0			7
5	3	8	1	1		13
6	5	9	3	0	1	18
7	0	8	1	0	0	9
Total	9	52	9	1	2	73
5th Grade Girls						
Original Teacher Rating						
1	0	2				2
2	0	6	1	1	1	9
3	2	1	0	1		4
4	4	12	2			18
5	1	8	1			10
6	2	5				7
7	0	4	1			5
Total	9	38	5	2	1	55
5th Grade Boys						
Original Teacher Rating						
1	1	3				4
2	1	7	2			10
3	0	9	1			10
4	5	10	5	1		21
5	3	16	3			22
6	2	17	1		1	21
7	2	4	1			7
Total	14	66	13	1	1	95

TABLE 16

Child's Reaction to Psychiatrist as Judged by Psychiatrist During Interview Compared With Original Teacher Rating of School Adjustment

	Strongly Positive	Slightly Positive	Neutral Reaction	Slightly Negative	Strongly Negative	Other	Insufficient Data	Total Number Interviewed
2nd Grade Girls Original Teacher Rating								
1	0	3	1					4
2	3	2	1	2				8
3	2	15	2	1	2	1		23
4	2	2	3	1				8
5	4	9	1	1				15
6	2	3	3			1	1	10
7	2	4	1					7
Total	15	38	12	5	2	2	1	75
2nd Grade Boys Original Teacher Rating								
1	2	3	4					9
2	2	4	2					8
3	1	3	4		1			9
4	2	2	2	1				7
5	3	6	2	1	1			13
6	3	6	9					18
7	3	2	3			1		9
Total	16	26	33	2	2	1		73
5th Grade Girls Original Teacher Rating								
1	0	2						2
2	1	4	2		1		1	9
3	1	1	1		1			4
4	3	10	2	3				18
5	2	4	3	1				10
6	1	3	3					7
7	0	3	1			1		5
Total	8	27	12	4	2	1	1	55
5th Grade Boys Original Teacher Rating								
1	1	2	1					4
2	0	8	1	1				10
3	1	3	5				1	10
4	5	8	4	2	2			21
5	1	7	7	4	2		1	22
6	4	8	5	4				21
7	2	2	3					7
Total	14	38	26	11	4		2	95

TABLE 17
Psychiatrist's Personal Reaction to Child Compared with Original Teacher Rating of School Adjustment

	Strongly Positive	Slightly Positive	Neutral Reaction	Slightly Negative	Strongly Negative	Other	Insufficient Data	Total Number Interviewed
2nd Grade Girls								
Original Teacher Rating								
1	3	0	1					4
2	1	5	1	0	1			8
3	3	11	7	2				23
4	1	5	2					8
5	3	9	1	1		1		15
6	0	8	2					10
7	1	4	2					7
Total	12	42	16	3	1	1		75
2nd Grade Boys								
Original Teacher Rating								
1	3	4	2					9
2	2	5	1					8
3	2	4	3					9
4	0	3	3			1		7
5	5	6	2					13
6	4	9	4	1				18
7	2	6	1					9
Total	18	37	16	1		1		73
5th Grade Girls								
Original Teacher Rating								
1	0	2	0					2
2	1	6	2					9
3	1	1	1	1				4
4	2	15	1					18
5	1	8	1					10
6	1	2	4					7
7	0	3	1	1				5
Total	6	37	10	2				55
5th Grade Boys								
Original Teacher Rating								
1	2	2						4
2	2	5	3					10
3	1	3	6					10
4	6	10	5					21
5	1	11	8			2		22
6	2	14	4			1		21
7	0	6	1					7
Total	14	51	27			3		95

TABLE 18

Total Number of Symptoms Manifested by Child During Psychiatric Interview Compared With Original Teacher Rating of School Adjustment

	Total Number of Symptoms										
	0	1	2	3	4	5	6	7	8	9	Total Number Interviewed
2nd Grade Girls											
Original Teacher Rating											
1	3	0	0	1							4
2	1	3	3	1							8
3	13	6	1	0	2	0	0	1			23
4	3	2	1	2							8
5	8	4	2	1							15
6	2	5	1	1	0	0	1	0	0		10
7	3	2	0	0	0	1	0	0	1		7
Total	33	22	8	6	2	1	1	1	1		75
2nd Grade Boys											
Original Teacher Rating											
1	5	1			2		1				9
2	6			2							8
3	3	2	1	1	1			1			9
4	1	3	2	0	1						7
5	8	2	1	1			1				13
6	6	4	2	3	3						18
7	3	1	1	1		2			1		9
Total	32	13	7	8	7	2	2	1	1		73
5th Grade Girls											
Original Teacher Rating											
1	0	1	0	0	0	1					2
2	5	1	2	0	1						9
3	2	1	1								4
4	5	8	1	3		1					18
5	6	2		1	1						10
6	2	2	2	1							7
7	2	0	2								4
Total	22	15	8	5	2	2					54
5th Grade Boys											
Original Teacher Rating											
1	2	0	2								4
2	2	4	1	1	1				1		10
3	4	2	1	1		2					10
4	7	6	3	4	1						21
5	7	8	1	2	2		2				22
6	5	9	6			1					21
7	2	2	2							1	7
Total	29	31	16	8	4	3	2		1	1	95

RELATIONSHIP OF INDIVIDUAL INTELLIGENCE TEST RESULTS TO CONSENSUS CLINICAL JUDGMENT OF SCHOOL ADJUSTMENT

TABLE 19

Estimated WISC Verbal IQ Compared With Consensus Clinical Judgment Of Good and Poor School Adjustment

	65-75	80-90	95-105	110-120	125-135	140+	Total Number Interviewed
2nd Grade Girls Clinical Group							
1. Consensus Well Adjusted	0	2	8	4			14
2. Neither Well nor Poorly Adjusted	4*	16	16	11	3		50
3. Consensus Poorly Adjusted	3	2	4	0	1		10
Total	7	20	28	15	4		74
2nd Grade Boys Clinical Group							
1. Consensus Well Adjusted	0	0	1	4	4	1	10
2. Neither Well nor Poorly Adjusted	3	13	20	10	3		49
3. Consensus Poorly Adjusted	5	3	3	3			14
Total	8	16	24	17	7	1	73
5th Grade Girls Clinical Group							
1. Consensus Well Adjusted	0	1	1	8	1		11
2. Neither Well nor Poorly Adjusted	2	10	22	7	1		42
3. Consensus Poorly Adjusted	3						3
Total	5	11	23	15	2		56
5th Grade Boys Clinical Group							
1. Consensus Well Adjusted	0	0	0	3	1	1	5
2. Neither Well nor Poorly Adjusted	1	15	31	17	7	1	72
3. Consensus Poorly Adjusted	1	8	5	4	1		19
Total	2	23	36	24	9	2	96

*1 at 60

TABLE 20

Estimated WISC Performance IQ Compared With Consensus Clinical Judgment Of Good and Poor School Adjustment

	65-75	80-90	95-105	110-120	125-135	140-150	155+	Total Number Interviewed
2nd Grade Girls Clinical Group								
1. Consensus Well Adjusted	0	0	4	6	4			14
2. Neither Well nor Poorly Adjusted	2	9	17	17	5			50
3. Consensus Poorly Adjusted	1	1	4	3	0		1	10
Total	3	10	25	26	9		1	74
2nd Grade Boys Clinical Group								
1. Consensus Well Adjusted	0	0	2	3	4	1		10
2. Neither Well nor Poorly Adjusted	4	10	18	11	6			49
3. Consensus Poorly Adjusted	1	4	8	1				14
Total	5	14	28	15	10	1		73
5th Grade Girls Clinical Group								
1. Consensus Well Adjusted	0	0	3	4	3	0	1	11
2. Neither Well nor Poorly Adjusted	1	14	13	8	5	1		42
3. Consensus Poorly Adjusted	1	2						3
Total	2	16	16	12	8	1	1	56
5th Grade Boys Clinical Group								
1. Consensus Well Adjusted	0	0	2	0	2	0	1	5
2. Neither Well nor Poorly Adjusted	6	11	24	17	12	2		72
3. Consensus Poorly Adjusted	0	7	5	3	3	1		19
Total	6	18	31	20	17	3	1	96

TABLE 21

Difference Between Estimated Verbal & Estimated Performance WISC IQs (Verbal-Performance) and Consensus Clinical Judgment of Good and Poor School Adjustment

	More than -20	-20 to -10	±10	+10 to +20	More than + 20	Total Number Interviewed
2nd Grade Girls Clinical Group						
1. Consensus Well Adjusted	1	7	6			14
2. Neither Well nor Poorly Adjusted	6	14	27	1	2	50
3. Consensus Poorly Adjusted	4	2	3	1		10
Total	11	23	36	2	2	74
2nd Grade Boys Clinical Group						
1. Consensus Well Adjusted	3	1	1	5		10
2. Neither Well nor Poorly Adjusted	6	10	28	4	1	49
3. Consensus Poorly Adjusted	1	5	6	2		14
Total	10	16	35	11	1	73
5th Grade Girls Clinical Group						
1. Consensus Well Adjusted	1	1	9			11
2. Neither Well nor Poorly Adjusted	8	7	19	7	1	42
3. Consensus Poorly Adjusted	0	2	1			3
Total	9	10	29	7	1	56
5th Grade Boys Clinical Group						
1. Consensus Well Adjusted	1	1	3			5
2. Neither Well nor Poorly Adjusted	10	12	39	6	5	72
3. Consensus Poorly Adjusted	5	3	10	0	1	19
Total	16	16	52	6	6	96

TABLE 22

Estimated WISC Full Scale IQ Compared With Consensus Clinical Judgment Of Good and Poor School Adjustment

	65-75	80-90	95-105	110-120	125-135	140+	Interviewed
2nd Grade Girls Clinical Group							
1. Consensus Well Adjusted	0	0	8	5	1		14
2. Neither Well nor Poorly Adjusted	3	7	24	12	4		50
3. Consensus Poorly Adjusted	0	5	4	0	0	1	10
Total	3	12	36	17	5	1	74
2nd Grade Boys Clinical Group							
1. Consensus Well Adjusted	0	0	1	3	4	2	10
2. Neither Well nor Poorly Adjusted	1	12	25	10	3		49
3. Consensus Poorly Adjusted	1	6	5	2			14
Total	2	18	31	15	7	2	75
5th Grade Girls Clinical Group							
1. Consensus Well Adjusted	0	0	3	4	3	1	11
2. Neither Well nor Poorly Adjusted	0	14	18	8	2		42
3. Consensus Poorly Adjusted	2	1					3
Total	2	15	21	12	5	1	56
5th Grade Boys Clinical Group							
1. Consensus Well Adjusted	0	0	1	2	0	2	5
2. Neither Well nor Poorly Adjusted	1	12	29	21	9		72
3. Consensus Poorly Adjusted	0	8	5	3	3		19
Total	1	20	35	26	12	2	96

RELATIONSHIP BETWEEN CONSENSUS CLINICAL JUDGMENT AND PUPILS' ACHIEVEMENT STATUS IN SCHOOL

TABLE 23

Difference in Chronological Age and Grade Age (CA-GA) Compared With Consensus Clinical Judgment of Good and Poor School Adjustment

Older or Younger than Grade

	7-10 Mo. Younger	1-6 Mo. Younger	0-5 Mo. Older	6-9 Mo. Older	Total Number Interviewe
2nd Grade Girls Clinical Group					
1. Consensus Well Adjusted	0	7	4	2	13
2. Neither Well nor Poorly Adjusted	4	37	9		50
3. Consensus Poorly Adjusted	0	9	1		10
Total	4	53	14	2	73
2nd Grade Boys Clinical Group					
1. Consensus Well Adjusted	1	7	2		10
2. Neither Well nor Poorly Adjusted	2	31	14	3	50
3. Consensus Poorly Adjusted	1	8	5		14
Total	4	46	21	3	74
5th Grade Girls Clinical Group					
1. Consensus Well Adjusted	2	6	3		11
2. Neither Well nor Poorly Adjusted	4	19	16	2	41
3. Consensus Poorly Adjusted	0	1	2		3
Total	6	26	21	2	55
5th Grade Boys Clinical Group					
1. Consensus Well Adjusted	2	2	1		5
2. Neither Well nor Poorly Adjusted	4	37	27	2	70
3. Consensus Poorly Adjusted	2	9	7	1	19
Total	8	48	35	3*	94

*7-18 Mo. older

TABLE 24

Difference Between Reading Achievement Grade Placement And Chronological Age Grade Placement (RGP-CAGP) Compared With Consensus Clinical Judgment of Good and Poor School Adjustment

	Below Or Above Grade in Reading					
	More than 1 yr. below grade	$-\frac{1}{2}$ to 1 yr. below grade	$\pm \frac{1}{2}$ yr. from grade	$\frac{1}{2}$ to 1 yr. above grade	More than 1 yr. above grade	Total Number Interviewed
2nd Grade Girls Clinical Group						
1. Consensus Well Adjusted	0	0	13	0	1	14
2. Neither Well nor Poorly Adjusted	1	0	47	0	2	50
3. Consensus Poorly Adjusted	0	1	8	1		10
Total	1	1	68	1	3	74
2nd Grade Boys Clinical Group						
1. Consensus Well Adjusted	0	0	9	0	1	10
2. Neither Well nor Poorly Adjusted	3	2	44	1		50
3. Consensus Poorly Adjusted	2	0	12			14
Total	5	2	65	1	1	74
5th Grade Girls Clinical Group						
1. Consensus Well Adjusted	0	0	5	2	4	11
2. Neither Well nor Poorly Adjusted	1	7	24	5	4	41
3. Consensus Poorly Adjusted	3					3
Total	4	7	29	7	8	55
5th Grade Boys Clinical Group						
1. Consensus Well Adjusted	0	0	3	1	1	5
2. Neither Well nor Poorly Adjusted	9	8	39	7	7	70
3. Consensus Poorly Adjusted	6	2	8	2	1	19
Total	15	10	50	10	9	94

TABLE 25

Difference Between Arithmetic Achievement Grade Placement And Chronological Age Grade Placement (AGP-CAGP) Compared with Consensus Clinical Judgment of Good and Poor School Adjustment

	Below Grade	Grade Level to ½ yr. Above	½ yr.- 1 yr. Above	More than 1 yr. Above	Total Number Interviewed
2nd Grade Girls Clinical Group					
1. Consensus Well Adjusted	0	12	0	2	14
2. Neither Well nor Poorly Adjusted	0	47	0	3	50
3. Consensus Poorly Adjusted	0	10			10
Total	0	69	0	5	74
2nd Grade Boys Clinical Group					
1. Consensus Well Adjusted	0	10			10
2. Neither Well nor Poorly Adjusted	0	48	1	1	50
3. Consensus Poorly Adjusted	1	13			14
Total	1	71	1	1	74
5th Grade Girls Clinical Group					
1. Consensus Well Adjusted	0	6	3	2	11
2. Neither Well nor Poorly Adjusted	8	21	9	3	41
3. Consensus Poorly Adjusted	3				3
Total	11	27	12	5	55
5th Grade Boys Clinical Group					
1. Consensus Well Adjusted	0	2	3		5
2. Neither Well nor Poorly Adjusted	11	43	9	6	69
3. Consensus Poorly Adjusted	7	6	3	2	18
Total	18	51	15	8	92

TABLE 26

Grade in Reading at end of Fall Semester, January 1962, Compared with Consensus Clinical Judgment of Good and Poor School Adjustment

Reading Grade

	F	D	C	B	A	Total Number Interviewed
2nd Grade Girls						
Clinical Group						
1. Consensus Well Adjusted	0	0	7	3	4	14
2. Neither Well Nor Poorly Adjusted	0	2	24	18	5	49
3. Consensus Poorly Adjusted	0	2	6	1	1	10
Total	0	4	37	22	10	73
2nd Grade Boys						
Clinical Group						
1. Consensus Well Adjusted	0	0	3	6	1	10
2. Neither Well Nor Poorly Adjusted	1	6	36	7	50	50
3. Consensus Poorly Adjusted	1	6	7			14
Total	2	12	46	13	51	74
5th Grade Girls						
Clinical Group						
1. Consensus Well Adjusted	0	0	2	6	3	11
2. Neither Well Nor Poorly Adjusted	0	1	19	16	5	41
3. Consensus Poorly Adjusted	0	0	2	1		3
Total	0	1	23	23	8	55
5th Grade Boys						
Clinical Group						
1. Consensus Well Adjusted	0	0	1	1	3	5
2. Neither Well Nor Poorly Adjusted	0	5	30	25	8	68
3. Consensus Poorly Adjusted	0	7	8	1	3	19
Total	0	12	39	27	14	92

TABLE 27

Grade in Arithmetic at End of Fall Semester, January 1962, Compared With Consensus Clinical Judgment of Good and Poor School Adjustment

	Arithmetic Grade					
	F	D	C	B	A	Total Number Interviewed
2nd Grade Girls						
Clinical Group						
1. Consensus Well Adjusted	0	0	7	5	2	14
2. Neither Well Nor Poorly Adjusted	0	3	25	16	5	49
3. Consensus Poorly Adjusted	0	5	4	1		10
Total	0	8	36	22	7	73
2nd Grade Boys						
Clinical Group						
1. Consensus Well Adjusted	0	0	1	7	2	10
2. Neither Well Nor Poorly Adjusted	1	6	26	16	1	50
3. Consensus Poorly Adjusted	0	3	11			14
Total	1	9	38	23	3	74
5th Grade Girls						
Clinical Group						
1. Consensus Well Adjusted	0	0	4	5	2	11
2. Neither Well Nor Poorly Adjusted	0	3	22	14	2	41
3. Consensus Poorly Adjusted	0	1	1	1		3
Total	0	4	27	20	4	55
5th Grade Boys						
Clinical Group						
1. Consensus Well Adjusted	0	0	1	2	2	5
2. Neither Well Nor Poorly Adjusted	0	5	29	26	9	69
3. Consensus Poorly Adjusted	0	6	11	1	1	19
Total	0	11	41	29	12	93

TABLE 28

Grade in Language Assigned at End of Fall Semester, January 1962, Compared With Consensus Clinical Judgment of Good and Poor School Adjustment

	Language Grade					
	F	D	C	B	A	Total Number Interviewed
2nd Grade Girls Clinical Group						
1. Consensus Well Adjusted	0	6	7	1		14
2. Neither Well Nor Poorly Adjusted	0	1	32	14	2	49
3. Consensus Poorly Adjusted	0	0	7	2	1	10
Total	0	7	46	17	3	73
2nd Grade Boys Clinical Group						
1. Consensus Well Adjusted	0	0	3	4	3	10
2. Neither Well Nor Poorly Adjusted	1	2	37	8	2	50
3. Consensus Poorly Adjusted	0	3	10	1		14
Total	1	5	50	13	5	74
5th Grade Girls Clinical Group						
1. Consensus Well Adjusted	0	0	4	3	4	11
2. Neither Well Nor Poorly Adjusted	0	1	20	17	3	41
3. Consensus Poorly Adjusted	0	0	3			3
Total	0	1	27	20	7	55
5th Grade Boys Clinical Group						
1. Consensus Well Adjusted	0	0	1	3	1	5
2. Neither Well Nor Poorly Adjusted	0	1	38	24	6	69
3. Consensus Poorly Adjusted	0	3	13	1	2	19
Total	0	4	52	28	9	93

TABLE 29

Grade in Social Studies Assigned at end of Fall Semester, January 1962, Compared With Consensus Clinical Judgment of Good and Poor School Adjustment

Social Studies Grade

	F	D	C	B	A	Total Number Interviewed
2nd Grade Girls Clinical Group						
1. Consensus Well Adjusted	0	0	7	7		14
2. Neither Well Nor Poorly Adjusted	0	0	33	16		49
3. Consensus Poorly Adjusted	0	0	8	1	1	10
Total	0	0	48	24	1	73
2nd Grade Boys Clinical Group						
1. Consensus Well Adjusted	0	0	5	4	1	10
2. Neither Well Nor Poorly Adjusted	1	0	36	13		50
3. Consensus Poorly Adjusted	0	0	12	2		14
Total	1	0	53	19	1	74
5th Grade Girls Clinical Group						
1. Consensus Well Adjusted	0	0	3	3	5	11
2. Neither Well Nor Poorly Adjusted	0	1	22	16	2	41
3. Consensus Poorly Adjusted	0	1	2			3
Total	0	2	27	19	7	55
5th Grade Boys Clinical Group						
1. Consensus Well Adjusted	0	0	1	2	2	5
2. Neither Well Nor Poorly Adjusted	0	3	32	28	6	69
3. Consensus Poorly Adjusted	0	1	12	6		19
Total	0	4	45	36	8	93

TABLE 30

Number of Unsatisfactory Marks in Citizenship
On Report Card at End of Fall Semester, January 1962,
Compared With Consensus Clinical Judgment of Good and Poor School Adjustment

	0	1	2	3	4-7	Total Number Interviewed
2nd Grade Girls						
Clinical Group						
1. Consensus Well Adjusted	13	1				14
2. Neither Well Nor Poorly Adjusted	45	4	1			50
3. Consensus Poorly Adjusted	9	0	1			10
Total	67	5	2			74
2nd Grade Boys						
Clinical Group						
1. Consensus Well Adjusted	9	0	0	0	1	10
2. Neither Well Nor Poorly Adjusted	34	5	5	5	1	50
3. Consensus Poorly Adjusted	3	3	3	2	3	14
Total	46	8	8	7	5	74
5th Grade Girls						
Clinical Group						
1. Consensus Well Adjusted	11					11
2. Neither Well Nor Poorly Adjusted	33	5	1	1	1	41
3. Consensus Poorly Adjusted	2	1				3
Total	46	6	1	1	1	55
5th Grade Boys						
Clinical Group						
1. Consensus Well Adjusted	4	0	1			5
2. Neither Well Nor Poorly Adjusted	48	7	9	4	2	70
3. Consensus Poorly Adjusted	12	2	3	2		19
Total	64	9	13	6	2	94

INFORMATION FROM THE HEALTH CARD RELATED TO CONSENSUS CLINICAL JUDGMENT OF SCHOOL ADJUSTMENT STATUS

TABLE 31

Number of Days Absent During Fall Semester 1961 Compared With Consensus Clinical Judgment of Good and Poor School Adjustment

Number of Days Absent

	0-5	6-10	11-14	15 or more	Total Number Interviewed
2nd Grade Girls					
Clinical Group					
1. Consensus Well Adjusted	8	4	0	2	14
2. Neither Well Nor Poorly Adjusted	28	17	3	2	50
3. Consensus Poorly Adjusted	4	3	1	2	10
Total	40	24	4	6	74
2nd Grade Boys					
Clinical Group					
1. Consensus Well Adjusted	4	3	3		10
2. Neither Well Nor Poorly Adjusted	26	18	4	2	50
3. Consensus Poorly Adjusted	3	7	3	1	14
Total	33	28	11	3	74
5th Grade Girls					
Clinical Group					
1. Consensus Well Adjusted	7	3	1		11
2. Neither Well Nor Poorly Adjusted	24	12	4	1*	41
3. Consensus Poorly Adjusted	1	1	0	1*	3
Total	32	16	5	2	55
5th Grade Boys					
Clinical Group					
1. Consensus Well Adjusted	3	2			5
2. Neither Well Nor Poorly Adjusted	52	10	6	2	70
3. Consensus Poorly Adjusted	13	4	2		19
Total	68	16	8	2	94

*28-32 days absent

TABLE 32

Number of Times Tardy During 1961 Fall Semester Compared With Consensus Clinical Judgment of Good and Poor School Adjustment

	Number of Tardies					
	0	1	2	3	4 or more	Total Number Interviewed
2nd Grade Girls Clinical Group						
1. Consensus Well Adjusted	14					14
2. Neither Well Nor Poorly Adjusted	45	0	2	1	2	50
3. Consensus Poorly Adjusted	10					10
Total	69	0	2	1	2	74
2nd Grade Boys Clinical Group						
1. Consensus Well Adjusted	9	1				10
2. Neither Well Nor Poorly Adjusted	43	2	2	1	2	50
3. Consensus Poorly Adjusted	14					14
Total	66	3	2	1	2	74
5th Grade Girls Clinical Group						
1. Consensus Well Adjusted	11					11
2. Neither Well Nor Poorly Adjusted	37	2	1	1		41
3. Consensus Poorly Adjusted	3					3
Total	51	2	1	1	0	55
5th Grade Boys Clinical Group						
1. Consensus Well Adjusted	5					5
2. Neither Well Nor Poorly Adjusted	62	5	2	1		70
3. Consensus Poorly Adjusted	16	1	0	1	1*	19
Total	83	6	2	2	1	94

*10 times

TABLE 33

Presence Of Any Vision Defect As Indicated on Cumulative Folder Compared With Consensus Clinical Judgment of Good and Poor School Adjustment

Vision Defect

	No	Yes	Total Number Interviewed
2nd Grade Girls Clinical Group			
1. Consensus Well Adjusted	11	3	14
2. Neither Well Nor Poorly Adjusted	39	11	50
3. Consensus Poorly Adjusted	9	1	10
Total	59	15	74
2nd Grade Boys Clinical Group			
1. Consensus Well Adjusted	9	1	10
2. Neither Well Nor Poorly Adjusted	42	8	50
3. Consensus Poorly Adjusted	12	2	14
Total	63	11	74
5th Grade Girls Clinical Group			
1. Consensus Well Adjusted	11	0	11
2. Neither Well nor Poorly Adjusted	35	6	41
3. Consensus Poorly Adjusted	3	0	3
Total	49	6	55
5th Grade Boys Clinical Group			
1. Consensus Well Adjusted	4	1	5
2. Neither Well nor Poorly Adjusted	63	8	71
3. Consensus Poorly Adjusted	14	5	19
Total	81	14	95

TABLE 34

Presence of Any Hearing Defect as Indicated on Cumulative Folder Compared With Consensus Clinical Judgment of Good and Poor School Adjustment

Hearing Defect

	No	Yes	Total Number Interviewed
2nd Grade Girls			
Clinical Group			
1. Consensus Well Adjusted	13	1	14
2. Neither Well Nor Poorly Adjusted	49	1	50
3. Consensus Poorly Adjusted	9	1	10
Total	71	3	74
2nd Grade Boys			
Clinical Group			
1. Consensus Well Adjusted	10	0	10
2. Neither Well Nor Poorly Adjusted	49	1	50
3. Consensus Poorly Adjusted	13	1	14
Total	72	2	74
5th Grade Girls			
Clinical Group			
1. Consensus Well Adjusted	11	0	11
2. Neither Well Nor Poorly Adjusted	40	1	41
3. Consensus Poorly Adjusted	3	0	3
Total	54	1	55
5th Grade Boys			
Clinical Group			
1. Consensus Well Adjusted	5	0	5
2. Neither Well Nor Poorly Adjusted	67	4	71
3. Consensus Poorly Adjusted	18	1	19
Total	90	5	95

BIRTH ORDER AND NUMBER OF SIBS COMPARED WITH CONSENSUS CLINICAL JUDGMENT OF SCHOOL ADJUSTMENT STATUS

TABLE 35

Birth Order of Pupil as Indicated on Cumulative Folder Compared With consensus Clinical Judgment of Good and Poor School Adjustment

Birth Order

	1st	2nd	3rd	4th	5th	6th	7th	Total Number Interviewed
2nd Grade Girls Clinical Group								
1. Consensus Well Adjusted	5	5	2	1	1			14
2. Neither Well Nor Poorly Adjusted	14	17	14	4	0	1		50
3. Consensus Poorly Adjusted	3	6	1					10
Total	22	28	17	5	1	1		74
2nd Grade Boys Clinical Group								
1. Consensus Well Adjusted	4	3	2	1				10
2. Neither Well Nor Poorly Adjusted	17	22	7	0	2	2		50
3. Consensus Poorly Adjusted	5	5	3	1				14
Total	26	30	12	2	2	2		74
5th Grade Girls Clinical Group								
1. Consensus Well Adjusted	3	4	3	1				11
2. Neither Well Nor Poorly Adjusted	21	12	6	2				41
3. Consensus Poorly Adjusted	0	2	0	1				3
Total	24	18	9	4				55
5th Grade Boys Clinical Group								
1. Consensus Well Adjusted	1	3	1					5
2. Neither Well Nor Poorly Adjusted	21	31	14	1	3	0	1	71
3. Consensus Poorly Adjusted	6	6	5	1				18
Total	28	40	20	2	3	0	1	94

TABLE 36

Number of Siblings in Family as Indicated On Cumulative Folder Compared With Consensus Clinical Judgment of Good and Poor School Adjustment

Number of Siblings

	0	1	2	3	4	5	6	7	Total Number Interviewed
2nd Grade Girls Clinical Group									
1. Consensus Well Adjusted	1	5	5	2	0	1			14
2. Neither Well Nor Poorly Adjusted	8	12	17	4	5	2	1		49
3. Consensus Poorly Adjusted	1	3	4	1	0	0	1		10
Total	10	20	26	7	5	3	2		73
2nd Grade Boys Clinical Group									
1. Consensus Well Adjusted	1	4	2	2	0	0	1		10
2. Neither Well Nor Poorly Adjusted	9	18	12	7	2	2			50
3. Consensus Poorly Adjusted	1	4	4	2	2	0	1		14
Total	11	26	18	11	4	2	2		74
5th Grade Girls Clinical Group									
1. Consensus Well Adjusted	1	4	2	3	1				11
2. Neither Well Nor Poorly Adjusted	14	12	10	3	0	2			41
3. Consensus Poorly Adjusted	0	0	2	1					3
Total	15	16	14	7	1	2			55
5th Grade Boys Clinical Group									
1. Consensus Well Adjusted	1	2	2						5
2. Neither Well Nor Poorly Adjusted	12	18	26	9	4	1	0	1	71
3. Consensus Poorly Adjusted	3	4	8	2	1				18
Total	16	24	36	11	5	1		1	94

MARITAL STATUS, OCCUPATION OF FATHER AND MOTHER AND EVIDENCE OF ETHNIC DIFFERENCES RELATED TO SCHOOL ADJUSTMENT STATUS

TABLE 37

Marital Status of Parents From Information on Cumulative Folder Compared With Consensus Clinical Judgment of Good and Poor School Adjustment

Marital Status of Parent

	Married	Other	Total Number Interviewed
2nd Grade Girls			
Clinical Group			
1. Consensus Well Adjusted	13	1	14
2. Neither Well Nor Poorly Adjusted	44	6	50
3. Consensus Poorly Adjusted	8	2	10
Total	65	9	74
2nd Grade Boys			
Clinical Group			
1. Consensus Well Adjusted	9	1	10
2. Neither Well Nor Poorly Adjusted	46	4	50
3. Consensus Poorly Adjusted	14	0	14
Total	69	5	74
5th Grade Girls			
Clinical Group			
1. Consensus Well Adjusted	10	1	11
2. Neither Well Nor Poorly Adjusted	38	3	41
3. Consensus Poorly Adjusted	3	0	3
Total	51	4	55
5th Grade Boys			
Clinical Group			
1. Consensus Well Adjusted	5	0	5
2. Neither Well Nor Poorly Adjusted	65	5	70
3. Consensus Poorly Adjusted	18	1	19
Total	88	6	94

TABLE 38

Occupation of Father as Indicated on Cumulative Folder Compared With Consensus Clinical Judgment of Good and Poor School Adjustment

Occupational Classification

	Professional & Managerial	Clerical & Sales	Service	Agricultural	Skilled	Semi-Skilled	Un-Skilled	Total Number Interviewed
2nd Grade Girls								
Clinical Group								
1. Consensus Well Adjusted	6	1	0	0	2	3	1	13
2. Neither Well Nor Poorly Adjusted	18	5	1	0	14	5	2	45
3. Consensus Poorly Adjusted	2	0	1	0	4			7
Total	26	6	2	0	20	8	3	65
2nd Grade Boys								
Clinical Group								
1. Consensus Well Adjusted	4	2	0	0	1	2		9
2. Neither Well nor Poorly Adjusted	14	2	4	1	15	4	5	45
3. Consensus Poorly Adjusted	3	0	1	0	4	2	3	13
Total	21	4	5	1	20	8	8	67
5th Grade Girls								
Clinical Group								
1. Consensus Well Adjusted	7	1	0	0	3			11
2. Neither Well Nor Poorly Adjusted	9	4	5	1	7	10	2	38
3. Consensus Poorly Adjusted	1	0	0	0	1	0	1	3
Total	17	5	5	1	11	10	3	52
5th Grade Boys								
Clinical Group								
1. Consensus Well Adjusted	2	2	0	0	0	1		5
2. Neither Well nor Poorly Adjusted	17	14	6	0	18	7	3	65
3. Consensus Poorly Adjusted	6	3	0	0	6	3		18
Total	25	19	6	0	24	11	3	88

TABLE 39

Mothers Classified as "Working" or as "Housewives" From Information on Cumulative Folders Compared With Consensus Clinical Judgment of Good and Poor School Adjustment

Working Status of Mother

	At Work	Housewife	Total Number Interviewed
2nd Grade Girls Clinical Group			
1. Consensus Well Adjusted	2	12	14
2. Neither Well Nor Poorly Adjusted	10	41	51
3. Consensus Poorly Adjusted	3	7	10
Total	15	60	75
2nd Grade Boys Clinical Group			
1. Consensus Well Adjusted	2	8	10
2. Neither Well Nor Poorly Adjusted	8	42	50
3. Consensus Poorly Adjusted	2	12	14
Total	12	62	74
5th Grade Girls Clinical Group			
1. Consensus Well Adjusted	2	9	11
2. Neither Well Nor Poorly Adjusted	6	36	42
3. Consensus Poorly Adjusted	0	3	3
Total	8	48	56
5th Grade Boys Clinical Group			
1. Consensus Well Adjusted	0	5	5
2. Neither Well Nor Poorly Adjusted	15	57	72
3. Consensus Poorly Adjusted	4	15	19
Total	19	67	96

TABLE 40

Whether Or Not a Foreign Language is Spoken In the Home As Indicated On Cumulative Folder Compared With Consensus Clinical Judgment of Good and Poor School Adjustment

	No	Yes	Total Number Interviewed
2nd Grade Girls Clinical Group			
1. Consensus Well Adjusted	13	1	14
2. Neither Well Nor Poorly Adjusted	44	6	50
3. Consensus Poorly Adjusted	8	2	10
Total	65	9	74
2nd Grade Boys Clinical Group			
1. Consensus Well Adjusted	9	1	10
2. Neither Well Nor Poorly Adjusted	45	5	50
3. Consensus Poorly Adjusted	8	6	14
Total	62	12	74
5th Grade Girls Clinical Group			
1. Consensus Well Adjusted	11	0	11
2. Neither Well Nor Poorly Adjusted	35	6	41
3. Consensus Poorly Adjusted	3	0	3
Total	49	6	55
5th Grade Boys Clinical Group			
1. Consensus Well Adjusted	5	0	5
2. Neither Well Nor Poorly Adjusted	66	4	70
3. Consensus Poorly Adjusted	19	0	19
Total	90	4	94

EVIDENCE OF GENETIC AND PHYSICAL FACTORS RELATED TO SCHOOL ADJUSTMENT AS DETERMINED FROM SOCIAL WORKER HOME INTERVIEW

TABLE 41

Comparison of Evidence in Social Worker Interview for Genetic Factors* Which May Have Affected Wholesome Development, Positively or Negatively, With Consensus Clinical Judgment of Good and Poor School Adjustment

Frequency of Genetic Factors Which May Have Affected Wholesome Development

	Positive	Negative	None Present	No Inquiry	Total Number Interviewed
2nd Grade Girls Clinical Group					
1. Consensus Well Adjusted	0	2	11	1	14
2. Neither Well nor Poorly Adjusted	1	8	39	1	49
3. Consensus Poorly Adjusted	0	2	8		10
Total	1	12	58	2	73
2nd Grade Boys Clinical Group					
1. Consensus Well Adjusted	0	1	8	1	10
2. Neither Well nor Poorly Adjusted	0	6	44		50
3. Consensus Poorly Adjusted	0	2	12		14
Total	0	9	64	1	74
5th Grade Girls Clinical Group					
1. Consensus Well Adjusted	0	0	11		11
2. Neither Well nor Poorly Adjusted	1	2	37	1	41
3. Consensus Poorly Adjusted	0	1	2		3
Total	1	3	50	1	55
5th Grade Boys Clinical Group					
1. Consensus Well Adjusted	0	0	5		5
2. Neither Well nor Poorly Adjusted	0	5	62	5	72
3. Consensus Poorly Adjusted	0	3	15		18
Total	0	8	82	5	95

*congenital defects and hereditary factors such as mental retardation, epilepsy, diabetes, etc.

TABLE 42

Comparison of Evidence in Social Worker Interview For Physical Defects* Which May Have Affected Wholesome Development, positively or negatively, With Consensus clinical Judgment of Good and Poor School Adjustment

Frequency of Physical Defects Which May have Affected Wholesome Development

	Positive	Negative	None Present	No Inquiry	Total Number Interviewed
2nd Grade Girls Clinical Group					
1. Consensus Well Adjusted	0	4	10		14
2. Neither Well nor Poorly Adjusted	4	16	29		49
3. Consensus Poorly Adjusted	0	4	6		10
Total	4	24	45		73
2nd Grade Boys Clinical Group					
1. Consensus Well Adjusted	0	1	8	1	10
2. Neither Well nor Poorly Adjusted	6	16	28		50
3. Consensus Poorly Adjusted	0	8	6		14
Total	6	25	42	1	74
5th Grade Girls Clinical Group					
1. Consensus Well Adjusted	2	3	6		11
2. Neither Well nor Poorly Adjusted	2	22	17		41
3. Consensus Poorly Adjusted	0	1	2		3
Total	4	26	25		55
5th Grade Boys Clinical Group					
1. Consensus Well Adjusted	0	1	4		5
2. Neither Well nor Poorly Adjusted	4	41	27		72
3. Consensus Poorly Adjusted	2	9	7		18
Total	6	51	38		95

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*Evidence of poor health history, illnesses, sensory organ defects, accidents, etc.

TABLE 43

Comparison of Evidence in Social Worker Interview For Physical Conditions* Which May Have Affected Wholesome Development, Positively or negatively, With Consensus Clinical Judgment of Good and Poor School Adjustment

Frequency of Physical Conditions Which May Have Affected Wholesome Development

	Positive	Negative	None Present	No Inquiry	Total Number Interviewed
2nd Grade Girls Clinical Group					
1. Consensus Well Adjusted	0	6	8		14
2. Neither Well nor Poorly Adjusted	5	18	26		49
3. Consensus Poorly Adjusted	0	6	4		10
Total	5	30	38	—	73
2nd Grade Boys Clinical Group					
1. Consensus Well Adjusted	0	1	8	1	10
2. Neither Well nor Poorly Adjusted	6	21	23		50
3. Consensus Poorly Adjusted	0	9	5		14
Total	6	31	36	1	74
5th Grade Girls Clinical Group					
1. Consensus Well Adjusted	2	3	6		11
2. Neither Well nor Poorly Adjusted	2	21	18		41
3. Consensus Poorly Adjusted	0	1	2		3
Total	4	25	26	—	55
5th Grade Boys Clinical Group					
1. Consensus Well Adjusted	0	1	4		5
2. Neither Well nor Poorly Adjusted	4	44	24		72
3. Consensus Poorly Adjusted	2	11	5		18
Total	6	56	33	—	95

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*Allergies, enuresis, nutrition, anemia, etc.

EVIDENCE FOR PSYCHOLOGICAL FACTORS RELATED TO SCHOOL ADJUSTMENT AS DETERMINED FROM SOCIAL WORKER HOME INTERVIEWS

TABLE 44

Comparison of Evidence in Social Worker Interview For Psychological Factors in the Parent-Child Relationship, Past or Present, Which May Have Affected Wholesome Development, Positively or Negatively, With Consensus Clinical Judgment of Good and Poor School Adjustment

Frequency of Evidence in Parent-Child Relationships Which May Have Affected Wholesome Development

	Positive	Negative	None Present	No Inquiry	Total Number Interviewed
2nd Grade Girls Clinical Group					
1. Consensus Well Adjusted	2	6	6		14
2. Neither Well nor Poorly Adjusted	13	20	16		49
3. Consensus Poorly Adjusted	0	9	1		10
Total	15	35	23	—	73
2nd Grade Boys Clinical Group					
1. Consensus Well Adjusted	2	1	6	1	10
2. Neither Well nor Poorly Adjusted	9	28	13		50
3. Consensus Poorly Adjusted	0	10	4		14
Total	11	39	23	1	74
5th Grade Girls Clinical Group					
1. Consensus Well Adjusted	3	2	6		11
2. Neither Well nor Poorly Adjusted	5	20	16		41
3. Consensus Poorly Adjusted	0	3	0		3
Total	8	25	22	—	55
5th Grade Boys Clinical Group					
1. Consensus Well Adjusted	1	1	3		5
2. Neither Well nor Poorly Adjusted	5	51	16		72
3. Consensus Poorly Adjusted	4	14			18
Total	10	66	19	—	95

TABLE 45

Comparison of Evidence in Social Worker Interview for Psychological Factors In Child's Relationship with Adults Other Than Parents Which May Have Affected Wholesome Development, Positively or Negatively, With Consensus Clinical Judgment of Good and Poor School Adjustment

Frequency of Evidence in Adult-Child Relationships Which May Have Affected Wholesome Development

	Positive	Negative	None Present	No Inquiry	Total Number Interviewed
2nd Grade Girls Clinical Group					
1. Consensus Well Adjusted	0	1	12	1	14
2. Neither Well nor Poorly Adjusted	1	3	36	9	49
3. Consensus Poorly Adjusted	0	2	5	3	10
Total	1	6	53	13	73
2nd Grade Boys Clinical Group					
1. Consensus Well Adjusted	1	1	6	2	10
2. Neither Well nor Poorly Adjusted	3	3	41	3	50
3. Consensus Poorly Adjusted	1	2	11		14
Total	5	6	58	5	74
5th Grade Girls Clinical Group					
1. Consensus Well Adjusted	0	0	8	3	11
2. Neither Well nor Poorly Adjusted	3	2	31	5	41
3. Consensus Poorly Adjusted	0	0	1	2	3
Total	3	2	40	10	55
5th Grade Boys Clinical Group					
1. Consensus Well Adjusted	0	1	4		5
2. Neither Well nor Poorly Adjusted	2	5	59	6	72
3. Consensus Poorly Adjusted	1	1	12	4	18
Total	3	7	75	10	95

TABLE 46

Comparison of Evidence in Social Worker Interview for Psychological Factors In Child's Relationship With Siblings Which May Have Affected Wholesome Development, Positively or Negatively, With Consensus Clinical Judgment of Good and Poor School Adjustment

Frequency of Evidence in Sibling Relationships
Which May Have Affected Wholesome Development

	Positive	Negative	None Present	No Inquiry	Total Number Interviewed
2nd Grade Girls Clinical Group					
1. Consensus Well Adjusted	1	3	10		14
2. Neither Well nor Poorly Adjusted	9	13	27		49
3. Consensus Poorly Adjusted	1	6	2	1	10
Total	11	22	39	1	73
2nd Grade Boys Clinical Group					
1. Consensus Well Adjusted	2	1	6	1	10
2. Neither Well nor Poorly Adjusted	10	6	34		50
3. Consensus Poorly Adjusted	0	7	7		14
Total	12	14	47	1	74
5th Grade Girls Clinical Group					
1. Consensus Well Adjusted	1	1	9		11
2. Neither Well nor Poorly Adjusted	5	12	23	1	41
3. Consensus Poorly Adjusted	0	2	1		3
Total	6	15	33	1	55
5th Grade Boys Clinical Group					
1. Consensus Well Adjusted	1	1	3		5
2. Neither Well nor Poorly Adjusted	2	26	43	1	72
3. Consensus Poorly Adjusted	2	8	6	2	18
Total	5	35	52	3	95

TABLE 47

Comparison of Evidence in Social Worker Interview For Psychological Factors In Child's Relationship With Peers Which May Have Affected Wholesome Development, Positively or Negatively, With Consensus Clinical Judgment of Good and Poor School Adjustment

	Frequency of Evidence in Peer Relationships Which May Have Affected Wholesome Development				
	Positive	Negative	None Present	No Inquiry	Total Number Interviewed
2nd Grade Girls Clinical Group					
1. Consensus Well Adjusted	2	2	10		14
2. Neither Well nor Poorly Adjusted	10	13	25	1	49
3. Consensus Poorly Adjusted	0	5	4	1	10
Total	12	20	39	2	73
2nd Grade Boys Clinical Group					
1. Consensus Well Adjusted	2	1	6	1	10
2. Neither Well nor Poorly Adjusted	7	8	32	3	50
3. Consensus Poorly Adjusted	0	6	8		14
Total	9	15	46	4	74
5th Grade Girls Clinical Group					
1. Consensus Well Adjusted	3	0	8		11
2. Neither Well nor Poorly Adjusted	4	9	27	1	41
3. Consensus Poorly Adjusted	0	1	2		3
Total	7	10	37	1	55
5th Grade Boys Clinical Groups					
1. Consensus Well Adjusted	1	0	4		5
2. Neither Well nor Poorly Adjusted	4	21	47		72
3. Consensus Poorly Adjusted	4	9	5		18
Total	9	30	56		95

SOCIAL FACTORS JUDGED TO BE RELATED TO SCHOOL ADJUSTMENT STATUS AS NOTED FROM SOCIAL WORKER INTERVIEW WITH PARENT AND OBSERVATION OF HOME AND NEIGHBORHOOD CONDITIONS

TABLE 48

Comparison of Evidence in Social Worker Interview For Social Factors Of Economic Deprivation* in the Home Which May Have Affected Wholesome Development, Positively or Negatively, With Consensus Clinical Judgment of Good and Poor School Adjustment

Frequency of Evidence of Economic Deprivation Which May Have Affected Wholesome Development

	Positive	Negative	None Present	No Inquiry	Total Number Interviewed
2nd Grade Girls Clinical Group					
1. Consensus Well Adjusted	0	1	13		14
2. Neither Well nor Poorly Adjusted	4	7	38		49
3. Consensus Poorly Adjusted	0	5	5		10
Total	4	13	56		73
2nd Grade Boys Clinical Group					
1. Consensus Well Adjusted	1	0	8	1	10
2. Neither Well nor Poorly Adjusted	1	16	33		50
3. Consensus Poorly Adjusted	0	5	9		14
Total	2	21	50	1	74
5th Grade Girls Clinical Group					
1. Consensus Well Adjusted	0	0	10	1	11
2. Neither Well nor Poorly Adjusted	1	10	30		41
3. Consensus Poorly Adjusted	0	1	2		3
Total	1	11	42	1	55
5th Grade Boys Clinical Group					
1. Consensus Well Adjusted	0	0	5		5
2. Neither Well nor Poorly Adjusted	1	8	63		72
3. Consensus Poorly Adjusted	1	5	12		18
Total	2	13	80		95

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*Family's past and present economic situation, including relief status, inadequate housing, food or clothing.

TABLE 49

Comparison of Evidence in Social Worker Interview For Social Factors Of Norm Conflict* in Family History Which May Have Affected Wholesome Development, Positively or Negatively, With Consensus Clinical Judgment of Good and Poor School Adjustment

Frequency of Evidence of Norm Conflict
Which May Have Affected Wholesome Development

	Positive	Negative	None Present	No Inquiry	Total Number Interviewed
2nd Grade Girls Clinical Group					
1. Consensus Well Adjusted	0	3	11		14
2. Neither Well nor Poorly Adjusted	4	8	37		49
3. Consensus Poorly Adjusted	0	4	6		10
Total	4	15	44	—	73
2nd Grade Boys Clinical Group					
1. Consensus Well Adjusted	2	1	6	1	10
2. Neither Well nor Poorly Adjusted	3	12	34	1	50
3. Consensus Poorly Adjusted	0	8	6		14
Total	5	21	46	2	74
5th Grade Girls Clinical Group					
1. Consensus Well Adjusted	0	1	10		11
2. Neither Well nor Poorly Adjusted	3	8	30		41
3. Consensus Poorly Adjusted	0	1	2		3
Total	3	10	42	—	55
5th Grade Boys Clinical Group					
1. Consensus Well Adjusted	1	1	3		5
2. Neither Well nor Poorly Adjusted	2	20	50		72
3. Consensus Poorly Adjusted	1	3	14		18
Total	4	24	67	—	95

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*Presence of cultural conflict including possible racial, national, religious, class or urban-rural factors between child's parents or between family and neighborhood

TABLE 50

Comparison of Evidence in Social Worker Interview of Social Disorganization* Which May Have Affected Wholesome Development, Positively or Negatively, With Consensus Clinical Judgment of Good and Poor School Adjustment

Frequency of Evidence of Social Disorganization
Which May have Affected Wholesome Development

	Positive	Negative	None Present	No Inquiry	Total Number Interviewed
2nd Grade Girls					
Clinical Group					
1. Consensus Well Adjusted	0	1	12	1	14
2. Neither Well nor Poorly Adjusted	0	3	46		49
3. Consensus Poorly Adjusted	0	2	8		10
Total	0	6	65	1	73
2nd Grade Boys					
Clinical Group					
1. Consensus Well Adjusted	0	0	9	1	10
2. Neither Well nor Poorly Adjusted	2	2	45	1	50
3. Consensus Poorly Adjusted	0	3	11		14
Total	2	5	65	2	74
5th Grade Girls					
Clinical Group					
1. Consensus Well Adjusted	0	1	10		11
2. Neither Well nor Poorly Adjusted	0	2	39		41
3. Consensus Poorly Adjusted	0	0	3		3
Total	0	3	52		55
5th Grade Boys					
Clinical Group					
1. Consensus Well Adjusted	0	1	4		5
2. Neither Well nor Poorly Adjusted	0	5	66	1	72
3. Consensus Poorly Adjusted	0	1	17		18
Total	0	7	87	1	95

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*Community or neighborhood characterized by social disorganization or anti-social patterns including the presence of delinquent sub-cultures.

TABLE 51

Comparison of Evidence in Social Worker Interview of Social Mobility* Which May Have Affected Wholesome Development, Positively or Negatively, With Consensus Clinical Judgment of Good and Poor School Adjustment

Frequency of Evidence of Social Mobility
Which May have Affected Wholesome Development

	Positive	Negative	None Present	No Inquiry	Total Number Interviewed
2nd Grade Girls Clinical Group					
1. Consensus Well Adjusted	0	1	13		14
2. Neither Well nor Poorly Adjusted	0	1	47	1	49
3. Consensus Poorly Adjusted	0	3	6	2	10
Total	0	5	66	2	73
2nd Grade Boys Clinical Group					
1. Consensus Well Adjusted	0	1	8	1	10
2. Neither Well nor Poorly Adjusted	1	1	48		50
3. Consensus Poorly Adjusted	0	1	13		14
Total	1	3	69	1	74
5th Grade Girls Clinical Group					
1. Consensus Well Adjusted	1	0	9	1	11
2. Neither Well nor Poorly Adjusted	0	1	39	1	41
3. Consensus Poorly Adjusted	0	0	3		3
Total	1	1	51	2	55
5th Grade Boys Clinical Group					
1. Consensus Well Adjusted	0	0	5		5
2. Neither Well nor Poorly Adjusted	0	4	67	1	72
3. Consensus Poorly Adjusted	0	0	17	1	18
Total	0	4	89	2	95

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*Family's geographic mobility which includes moving, locally or from city to city.

TABLE 52

Comparison of Evidence in Social Worker Interview for any Factor, Physical, Psychological or Social, Which May Have Affected, Positively or Negatively, Child's School Progress With Consensus Clinical Judgment of Good and Poor School Adjustment

Frequency of Evidence of Any Factor Which Affected School Adjustment

	Positive	Negative	None Present	No Inquiry	Total Number Interviewed
2nd Grade Girls Clinical Group					
1. Consensus Well Adjusted	1	6	7		14
2. Neither Well Nor Poorly Adjusted	13	20	16		49
3. Consensus Poorly Adjusted	0	9	1		10
Total	14	35	14		73
2nd Grade Boys Clinical Group					
1. Consensus Well Adjusted	2	0	7	1	10
2. Neither Well Nor Poorly Adjusted	9	27	14		50
3. Consensus Poorly Adjusted	0	13	1		14
Total	11	40	22	1	74
5th Grade Girls Clinical Group					
1. Consensus Well Adjusted	3	1	7		11
2. Neither Well nor Poorly Adjusted	6	24	11		41
3. Consensus Poorly Adjusted	0	3	0		3
Total	9	28	18		55
5th Grade Boys Clinical Group					
1. Consensus Well Adjusted	1	2	2		5
2. Neither Well nor Poorly Adjusted	7	51	14		72
3. Consensus Poorly Adjusted	2	15	1		18
Total	10	68	17		95

TABLE 53

Comparison of Original Teacher Rating With Consensus Clinical Judgment of Good and Poor School Adjustment

	Level of School Adjustment							Total Number Interviewed
	Best Adjustment					Poorest Adjustment		
	1	2	3	4	5	6	7	
2nd Grade Girls Clinical Group								
1. Consensus Well Adjusted	0	2	6	1	4	1		14
2. Neither Well nor Poorly Adjusted	4	5	15	7	7	7	6	51
3. Consensus Poorly Adjusted	0	1	2	0	4	2	1	10
Total	4	8	23	8	15	10	7	75
2nd Grade Boys Clinical Group								
1. Consensus Well Adjusted	5	2	2	0	0	1		10
2. Neither Well nor Poorly Adjusted	4	6	6	7	7	14	6	50
3. Consensus Poorly Adjusted	0	0	1	0	6	4	3	14
Total	9	8	9	7	13	19	9	74
5th Grade Girls Clinical Group								
1. Consensus Well Adjusted	0	4	0	3	4			11
2. Neither Well nor Poorly Adjusted	2	5	4	16	6	5	4	42
3. Consensus Poorly Adjusted	0	0	0	0	0	2	1	3
Total	2	9	4	19	10	7	5	56
5th Grade Boys Clinical Group								
1. Consensus Well Adjusted	1	2	1	0	0	1		5
2. Neither Well nor Poorly Adjusted	3	8	8	19	16	14	4	72
3. Consensus Poorly Adjusted	0	0	1	3	6	6	3	19
Total	4	10	10	22	22	21	7	96